

University of Oslo
The Faculty of Medicine
Institute of Health and Society
Department of General Practice and Community Medicine



Child birth in rural India

From home births to incentive-based institutional deliveries

A qualitative study on experiences and perspectives in Uttar Pradesh



By Marianne Gjellestad

Supervisor: Babill Stray-Pedersen, Professor I, Dr.med.
Co-Supervisor: Ane Haaland, Lecturer and Communication adviser

Thesis submitted as a part of the Master of Philosophy Degree in International Community Health

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Oslo, May 2010

Marianne Gjellestad

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Abstract

Title: Child birth in rural India: From home births to incentive-based institutional deliveries. A qualitative study on experiences and perspectives in Uttar Pradesh.

Supervisor: Babill Stray-Pedersen, Professor I, Dr.med.

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Introduction

India contributes to 22% of the global burden of maternal mortality. With the recent implementation of Janani Suraksha Yojana (JSY), a governmental program giving incentives for institutional deliveries, the National Rural Health Mission (NRHM) has made an extensive change in the maternal practices. The target is to make at least 80% of the women deliver in hospitals and thus reduce the Maternal Mortality Ratio (MMR).

Objectives

The study aimed to increase the knowledge on the different perspectives after the recent change from home births to incentive-based institutional deliveries in the Hathras District, U.P., India. The main focus of my investigation was to enlighten the perspective of the women, and to see their experiences in relation to the perspective of health officials and midwives. Research questions comprised request about which parts of the NRHM/JST were utilized and why, and how this would affect the situation.

Methodology and research design

Data was collected through semi-structured interviews from two different informant groups: 22 women who had recently delivered in a governmental institution and five health officials working on different levels in the NRHM. A third perspective was gained through the researcher's participation at an Indian midwife conference.

Findings/conclusions

The women in the Hathras District were overall satisfied with the experiences in the maternity institutions, even though a clear gap was identified between theory and practice in most of the investigated fields. Utilization of the services was highly associated with the work of the Accredited Social Health Activist (ASHA), but the mother-in-law seemed to be the main decision maker. Determination factors for delivering their babies in institutions were desire for medical safety and assistance, poor hygiene or lack of assistance in the homes and instructions from community leaders. The financial incentives were not mentioned as a reason for going to the facilities. The women's experiences in the institution revealed several questions around the quality of care, most urgent the frequent use of Oxytocin. Also the unofficial payments in the facilities represent a challenge. The movement toward institutional deliveries was found to have a possible influence on the women's relation to the health care system and on their way of viewing child birth as a natural versus a medical event. It was also found to possibly influence the family structure and contribute to empowerment of women.

Recommendations

Findings from this study suggest the importance of measuring what happens in the gap between intentions and implementations of NRHM and JSY, and the importance of investigating possibilities for improvements at this stage. Both quantitative and extended qualitative research is needed on the users' experiences. Research on health professionals' skills and attitudes will also be of importance for planning the future steps of the programs and understanding the mechanisms regarding sustainability. Finally, awareness and research on how to increase the empowerment of women should be encouraged.

Prologue

In the evening, when it just has become dark, I hear a noise outside. I see lighted lamps and people gathering out in the courtyard and hear excited voices. When I come out I see a young girl lying on what I first recognize as the back of a truck, but when I give it another look I see that it is a cart behind a mule. The girl is lying still, looking pale and exhausted, with her legs spread and uncovered. Between them lies a newborn baby.

The talking calms when the nurses come out of the house. The baby stretches her naked body, the skin reflecting the yellow light of the lamps. Around the cart stands a group of women in long colorful draperies. For a second the world is quiet.

It all happens at the same time. The mother gets up from the cart and gets ready to walk into the clinic. Someone flashes a light to take a photo of the beautiful sight. The mule gets scared and makes an abrupt movement. The mother collapses and faints. The women in the colorful clothing are all over her, calling for the men, who then come and carry her inside.

Out in the courtyard, the peace settles again. The baby, still lying in the cart, is taken care of by new hands.

I have seen my first mother with her newborn baby in a foreign country.

List of abbreviations

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
EmOC	Emergency Obstetric Care
JSY	Janani Suraksha Yojana ¹
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MPHC	Methodist Public Health Center
NIPi	Norway India Partnership Initiative
NRHM	National Rural Health Mission
PHC	Primary Health Center
PNC	Post Natal Care
SBA	Skilled Birth Attendant
Sida	Swedish International Development Cooperation Agency
TBA	Traditional Birth Attendant
UNICEF	United Nations' Children's Fund
UNFPA	United Nations Population Fund
U.P.	Uttar Pradesh
WHO	World Health Organization

¹ Hindi for “pregnant women safety scheme”. Name of a program giving incentives for deliveries in governmental institutions.

1.0 Introduction

Globally more than half a million women die every year from pregnancy or child-birth-related complications. The majority of these deaths happen in low income countries, and most of them are avoidable. (1) India contributes to 22% of the global burden of maternal mortality. With a population of 1.15 billion and a maternal mortality ratio (MMR) at 301, India is the country counting for the highest number of deaths alone. (2)

The United Nations Millennium Declaration was signed in year 2000. From this declaration the eight Millennium Development Goals (MDGs) were formulated, and the world's leaders stated their commitments. (3) Improvement of maternal health is addressed with two targets in goal number five, MDG5: target one is to reduce the maternal mortality ratio by three quarters, and target two is to achieve universal access to reproductive health. The time span for the reduction is 1990-2015. Numbers from 1997-2003 show that maternal mortality in India has declined. A decline from 504 to 301 deaths per 100.000 live births indicates that while the country is developing in the right direction, it is unlikely to meet MDG5. (2)

The access to skilled care during birth is considered a major factor for safe motherhood. To deliver in an institution is also considered crucial, both for ensuring the skilled attendance and for needed equipment and medicines. (4) Research from the rural parts of India shows that more than 65% of deliveries occur at home. (5) The country's health care system is characterized by huge inequalities, and there are thorough differences both between rich and poor and between life in urban and rural areas. India's economy is rapidly growing, and the resultant growth in private health services contributes to maintain, or even enlarge, the differences; access to health care is a varying good.

There have been a series of plans and projects to improve the situation through the history. Since India gained its independence in 1947, numerous programs have been introduced and implemented to regulate and improve access to care. (6) One policy instrument that has been used in the poorest parts of the population is payment of incentives. Incentive-based services mean that a person gets cash or other payments to use certain services. During the last decade women living below the poverty level have been offered incentives for giving childbirth in governmental facilities in some Indian states. With the launching of the extensive National Rural Health Mission (NRHM) in 2005, the Indian government started a program giving incentives to all women for institutional deliveries, regardless of their financial situation. This

program is named Janani Suraksha Yojana (JSY) and is, by promoting institutional deliveries, considered one of the main components to reduce maternal and child mortality. (7) Norway supports the NRHM with money and technical assistance through the Norway India Partnership Initiative (NIPI). This was initially a collaboration to meet MDG4, but later MDG 5 has also been included in the program. (8;9)

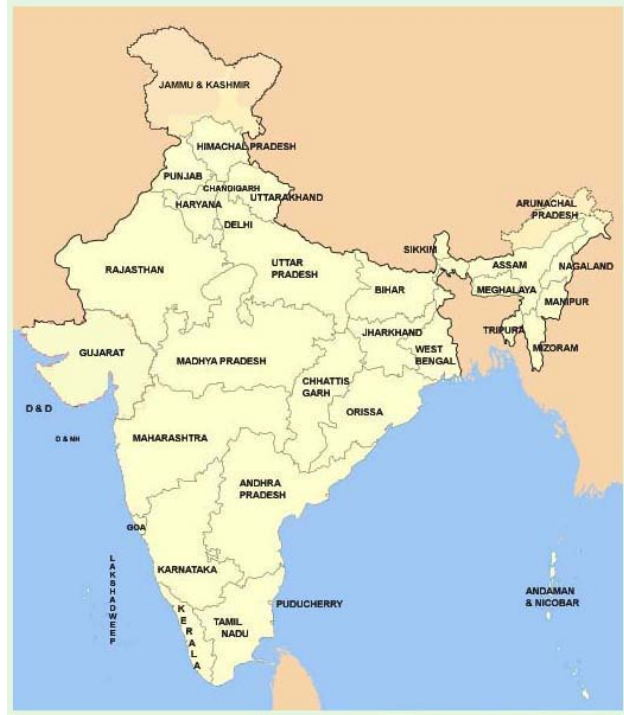
NRHM and JSY are based on medical guidelines developed in accordance with international standards, with considering focus on the availability of skilled birth attendance and emergency obstetric care as key factors for reducing MMR. How implementations will work in the specific contexts is still unknown, and one can ask whether local resources and needs have been taken into consideration in the planning process. The number of institutional deliveries has increased considerably after the JSY. An assessment based on statistics from five states show that 54.9% of the deliveries in 2008 took place in an institution, which was an increase from 23.5% in 2006. (10) Still, research shows that previously there have been several reasons for the women to deliver at home, regarding psychosocial, cultural and traditional conditions. (5) This gives reason to believe that the women's experiences after the changes toward institutional deliveries will represent an interesting and important perspective to explore.

This study aimed to increase the knowledge about the women's experiences with the recent change from home births to institutional deliveries in the Hathras District in the state Uttar Pradesh in north India. By interviewing both women who had recently given child birth in a governmental institution and health officials working at different levels in the programs, the target was to broaden the understanding of the different perspectives in the change. By the researcher's attendance at an International midwife conference in India, the data was also triangulated by adding learning and understandings from the midwives' perspective to the discussion.

1.1 Background

1.1.1 Demographic profile

The Republic of India is by area the biggest country in South-Asia and the seventh biggest country in the world. The country borders Pakistan, China, Nepal, Burma, Bangladesh and Bhutan, and with a long coastline it is also bounded by the Indian Ocean, the Arabian Sea and the Bay of Bengal. The population counts for 1.15 billion people; this makes it the second-most populated country in the world. (11) India gained independence from the British in 1947, and is today the world's most populated democracy. The country consists of 28 states and seven union territories, with New Delhi as the capital. India has one of the fastest growing economies in the world, and the GNP in 2009 was 3827 US



Map of India (7)

dollar per capita. (12) There are huge disparities in income, and despite the rising economy poverty and illiteracy are still widespread. The difference between life in urban and rural areas is large. While the population in the cities continues to increase rapidly, more than 70% of the people still live in rural areas.

India's major religion is Hinduism, with 82 % of the people being Hindus. Other big religions are Islam (13%), Christianity (3%), Sikhism (2%) and Buddhism (1%). (13) The most common language is Hindi, although there are numerous languages spoken in the country. The caste-system was officially abolished when the Constitution of India came into force in 1950. Still segregation and suppression of people from the lower castes, scheduled tribes and other minority groups exist, in spite of different political attempt to legislate equal rights for all. (14)

India is the home of numerous cultures, and this makes it a country so diverse it appears more as a continent than a country. Since this study mainly investigates life and health in one specific state, Uttar Pradesh, the more detailed demography of this state is provided.

Uttar Pradesh

Uttar Pradesh (U.P.) is India's fourth largest state. U.P. is located in the mid-north of the Indian continent, where it borders to Nepal in the north, Himachal Pradesh in the north-west, Haryana in the west, Rajasthan in the south-west, Madhya Pradesh in the south and Bihar in the east. U.P has a population of 166.20 million people. It is the most populous state in India, and it is also the state with the highest population growth rate. U.P. holds 71 districts, 813 blocks and 107.452 villages. (15) The name Uttar Pradesh means "the north state". It holds a broad spectrum of populations from different parts of India, which makes it a compound of different cultures and religions. Of the people in U.P., 74.7% live in rural areas with very limited facilities:

Percentage of households that	Rural U.P	India
Live in a house of solid construction	12.2	46
Have electricity	28.3	68
Have access to a toilet facility	16	45
Use piped drinking water	2.0	24.5

Numbers from NFHS-3. (13)

In the group of women of the age 15-44, 63.6% are non-literate (16) and 44.3% of women have experienced spousal violence. The sex ratio is 898 girls per 1000 boys. (13) Of the households, 11.7% have a motorized vehicle. Regular media exposure (TV, radio or newspaper at least once a week) is reported to be 44% for women and 72% for men. (13)

In 2008, 47.5% of the deliveries in U.P. took place in an institution. This was an increase from 20.6% in 2006. (10)

1.1.2 Maternal mortality in India

Maternal mortality in India is presented with current numbers varying from 254 to 301.(1;2;15) With a high percentage of the women delivering at home and not receiving any ante natal care, a correct number of complications or mortality is difficult to measure. Irrespective of confusing numbers and differences in the baseline, the sources agree that progress has been made; MMR in India is declining. Maternal morbidity and mortality also differs from state to state. In the state of U.P. MMR has declined from 517 to 440 in the period 2003- 2006, still leaving the state with a MMR higher than the national average. (15)

Causes of death

The most frequent causes of maternal deaths are severe bleeding (25%), infections (15%), eclampsia and hypertension-related diseases (12%), obstructed labour (8%) and unsafe abortions (13%). In addition come other direct causes (8%) and indirect causes (20%). (1) The registered mortality is suggested to be only a “tip of the iceberg”, with 20-30 women suffering severe morbidity for every death. (1) Difficult labour is also recognized as a major cause of infant mortality. Like the maternal mortality, India’s infant mortality is declining. In 2006 the measured number was 57, a reduction from 80 in 1991. (17)

Maternal care: A brief history

The organized work for mother and child health in India dates back to the beginning of the previous century, where rural midwives or Traditional Birth Attendants (TBAs) were trained to conduct safe deliveries. From 1918, Midwifery Supervisors were trained at the Lady Reading Health School in Delhi, and from 1931, the expanding work for mother and child health was coordinated under the Indian Red Cross Society. By this time some of the states also established agencies for maternal welfare, but the work progressed at a slow pace. From 1955 the government started to integrate the mother and child health in the general health services, and international agents, such as WHO and UNICEF, increased assistance to the country. (18)

The first Indian National Health Policy was framed in 1983. The target of this policy was to achieve “health for all” by the year 2000, where a central component in this work was the arrangement of primary health care services and the provision of primary health centers. (17)

Home deliveries and Traditional Birth Attendants (TBAs)

Until recent times, the traditional way of giving child birth in the rural parts of India has been to deliver at home. Here the women have been assisted by female relatives, by a TBA or by an Auxiliary Nurse Midwife (ANM). (5)

A TBA, also called dai², is a person who assists a mother during childbirth and who acquires her skills by delivering babies herself or through apprenticeship to other TBAs. (4) The expression TBA is an umbrella term including women with varying practices, according to local and personal differences. They are often respected in their community for their skills and knowledge, and they tend to be older, non-literate women. (19;20) Because such a high

² Dai is the Hindi expression for birth attendant, and also the expression used by the informants when talking about a TBA.

number of women traditionally have been assisted by TBAs at delivery, large efforts have been made to improve their skills by organized training. From the 70's WHO and the international society recommended and funded training programs, in India as well as in other low income countries. The target was to train the TBAs in basic skills for child delivery. From the beginning of the 90's persistently high MMR and poor documentation on the efficacy of the training led to an end to the programs. (19) In current plans and strategies TBAs are no longer considered effective resources in combating maternal mortality. Nevertheless, in some rural areas the major percentage of women still delivers at home without a skilled attendant. (5)



Re-training of TBAs in Hathras District

Institutional deliveries and Skilled Birth Attendants (SBAs)

Current strategies for reducing MMR in low income settings are now based on encouraging institutional deliveries with attendance of a Skilled Birth Attendant (SBA) and availability of Emergency Obstetric Care (EmOC). The term EmOC refers to the services of treatment for complications during pregnancy and child birth. (21) An SBA is defined by the WHO as a person with midwifery skills (for example doctor, midwife or nurse) who has been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer obstetric complications. (22) Thus, aiming at improving safe deliveries with these two components, the new focus is now to encourage women to come to an institution for child delivery.

In India, governmental services for providing delivery care have gone through an extensive change after the implementation of the National Rural Health Mission program started in 2005. Significant initiatives under this program include upgrading of facilities, incentives for institutional births and introduction of the new worker Accredited Social Health Activist (ASHA). Guidelines for the program are given from the central government, but implementation is delegated to the government of states. This causes services and standards of care to differ to some extent, depending on the situation in the individual state.

Coverage and training of midwives

Like most of India's rural areas, the rural parts of Uttar Pradesh have a vast unmet need for health personnel. Health indicators calculate a need for 7295 nurse/midwives in the state, and the number of positions currently occupied is less than half, 3340. (15) With the clear exception of male doctors at the PHCs, shortage of all types of health personnel is reported. Both health infrastructure and utilization of the services are connected with other types of demographic factors, as availability and possibilities are highly dependent on local context.

Today there are two types of midwife education in India. (23) The trained nurse midwife has a three-year nursing program containing six months of midwifery. This gives a degree and registration as both a nurse and a midwife. The Auxiliary Nurse Midwife (ANM) is a multipurpose female health worker with 18 months training, six of them in midwifery. Both groups are educated to manage normal deliveries, but responsibilities and tasks vary a lot depending on geography. The distribution between the two groups is also geographically skewed, with 90% of the trained nurse midwives working in urban areas, and 90% of the AMNs working in the rural areas. (23) The ANM has also traditionally attended home deliveries in rural areas. (19)

The organization Society of Midwives, India (SOMI) was launched and registered in 2000. This union for midwives works tightly with the nursing academies to improve midwifery services and professional integrity. Headquarter for SOMI is located in Hyderabad, and national conferences are arranged annually. (23)

1.1.3. The National Rural Health Mission

The National Rural Health Mission (NRHM) was launched by the Indian government in 2005. The program is an extensive initiative for reforming the access to basic health care in rural areas, especially focusing on women and children. Major focus areas are reproductive health, sanitation, hygiene, nutrition and safe drinking water. Eighteen high focus states with poor health services are given priority, among them Uttar Pradesh. The initiative seeks to make services equitable, affordable, accountable and effective in order to achieve better the health conditions and standards of living in the rural areas. (7)

The government has a policy of transparency in all segments of the program, and all reports and evaluations are available online. Implementation of the program is decentralized to state- and district management. The NRHM is planned to run till 2012.

The two most significant policies affecting women giving birth are the introduction of the Janani Suraksha Yojana (JSY) scheme and the creation of Accredited Social Health Activists (ASHAs). (7)

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is Hindi for "pregnant women safety scheme". In this program women or families are compensated for delivering in a governmental institution, receiving a one-time payment of 1400 Indian rupees (= 186 NOK). (7) The objective is compound, partly to make the mother deliver under safe conditions and with skilled attendance, and partly to get the children enlisted for vaccinations. The scheme is a modification of an earlier system, where incentives for institutional deliveries were given only to women below the poverty line. Now all women can receive a check-payment for delivering in a governmental institution, regardless of factors such as financial situation, number of children or geographic area. (24)

The Accredited Social Health Activist (ASHA)

The ASHA is a female social health worker, selected and trained to work in the community. She functions as a connection to public health services, and her payment is based on incentives for performance. She has a number of tasks, among them to follow the women to the institution for delivery and to follow up with vaccination programs in the community. The plan in the villages is to have one ASHA per 1000 population. (25) Women recruited to be trained as ASHA should preferably have attended school up till class eight. The training consists initially of 23 days in five episodes, and further training will be available for development of knowledge and skills.

1.1.4. The Norway India Partnership Initiative

The Norway India Partnership Initiative (NIPI) was initiated by the two countries' Prime Ministers, Manmohan Singh and Jens Stoltenberg, in 2005. In 2006 the letter of intent was signed, and a five year plan was developed. (8) The objective was to give administrative and financial support to implementation of the mother and child health programs under the NRHM. NIPI has a budget of 500 million NOK for the five-year period. The main target from the start was to meet the MDG4, and later MDG5 was also included in the formal target. NIPI also aims to identify and develop good solutions and strategies for working with mother and child health both locally and on a larger scale, with possibilities for transferring knowledge to other countries. In 2006 and 2007 agreements were made with WHO, UNICEF and UNOPS for funding and organization. (8)

NIPi in Uttar Pradesh

Five states were initially selected for the NIPi work, namely Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh. These five states were identified because of high population numbers and high IMR and MMR. In the other four states the work is under progress, but by the beginning of 2010, the work in U.P. has still not commenced.

When U.P. was chosen for this project it was still expected that NIPi would start working in the state; but by the time the field work in Hathras started, the program launch was shelved for the indefinite future. Even though U.P. is no longer considered a “NIPi-state”, their work is still relevant for this project and are therefore maintained as part of the framework: the challenges foreign agents meet in the U.P., NIPi’s policies and not at least the idea of NIPi’s new worker Yashoda are all relevant topics when discussing different perspectives on the changes after NRHM and JSY in U.P.

The Yashoda

One practical implementation from the work of NIPi is the introduction of the new health worker Yashoda. The Yashoda is a trained female health worker working in the hospital. Her main tasks are to give the mother support during delivery, promote early and exclusively breastfeeding and to encourage the mothers to stay at the hospital for 48 hours after time of delivery. The name Yashoda is taken from the name of the foster mother of Krishna, a main Hindi god. (7;26) The introduction of this worker is a strategy for encouraging the women to come to the governmental hospital for child delivery, and not at least to make them stay in the institution afterwards. The support from the Yashoda represents something new in the Indian hospital system, where care and support traditionally has been given mainly by the family members. The implementation of Yashoda is a strategy for giving the women another experience of the care in the facility, and through this also creating a possibility for teaching and informing the mothers about important health issues.

2.0 Literature Review

A review of literature was done during the planning phase of the study. Knowledge from relevant literature and research articles were presented at IASAM (UiO) in April 2009. During the field work new literature was added. For up-date, a new search was done in April 2010 with the same key words.

2.1 Literature search

The main search engines for the review were PubMed and Google Scholar. Further, the WHO, UN and NRHM websites, the curriculum of the master course, resource persons and the snowball method from articles already found were used. Key words for searching were delivery(ies), institutions, incentives, obstetric care, maternal mortality, traditional birth attendants, skilled birth attendants, emergency obstetric care, NRHM, JSY, ASHA, Yashoda and India, used in different combinations.

Theories and literature on methodology will be presented and used in the chapter on methodology.

2.2 Current knowledge

The Indian MMR is described as declining by both research and statistical sources. (5;7;13;17;24) Review- and research articles shows that different strategies are proposed to reduce the MMR, both in rural India and in other low-income settings. (27-30) Two main topics are identified to affect the outcomes; first having a Skilled Birth Attendant (SBA) for delivery and, second, giving birth at a facility with capacity for Emergency Obstetric Care (EmOC). (4) Even though promoting availability of these two resources is now considered the main procedure for combating MMR, several other factors are suggested to influence the impact of interventions. These factors are the economic, political, cultural, religious, psycho-social, strategic, administrative, managerial and historical aspects of the setting. (2;5;29;31;32) Lahariya (24) calls attention to the need for improvement in the facilities both regarding quality and capacity, to be able to accommodate the increasing number of women using the facilities. Trained staff is another factor identified to be important for the effect of EmOC. (29) Research from other low-income countries presents that institutional deliveries and need for EmOC can involve heavy expenses for the family and result in financial problems. (33)

The importance of a continuum of care with continuity during pregnancy, childbirth and the post natal period is emphasized; significantly, the focus on ante natal care is pointed out as a prerequisite for a successful program. (2;5;24)

Context and local differences are identified as key elements by Penn-Kekana, (34) showing that the strategy for implementation must be emphasized in all change involving human interactions.

Parts of the research, especially on the effect of the training of the TBAs, are conflicting and limited. (19) Nevertheless, results from studies on the TBAs coincide in their findings on several points. The effect of training is difficult to measure, both because most of the TBAs have already received some training when the intervention starts, and because of the combination with other programs. Another common finding is that more research is needed before reaching definitive conclusions. Qualitative studies also show that the role and the practice of the TBAs vary greatly from place to place, and thus it is difficult to generalize. (19;20)

Statistics from NRHM show that hospital deliveries in Uttar Pradesh increased from 11.2% to 47.5% in the period 1992- 2008. (7) It seems that NRHM and the introduction of JSY has been a success so far. Still, other sides of the programs are viewed critically, from both government and researchers. (6;7)

Determinants for the women's choices are elaborated in detail in different studies. (2;5;31) Matthews, Ramakrishna, Mahendra, Kilaru and Ganapathy (5) found that 89% of the women planned to deliver at home because they, among other factors, wanted to give birth in the cultural and traditional setting of a home delivery. Support from the family was another motivator. From this there is reason to question whether these women will experience a loss regarding culture, tradition and not least the needed support by having an institutional delivery. Experience of sufficient support, meaningfulness and relaxation are known to play major roles for women giving birth, for both psychological mechanisms and progress during the stages of labor. (35) The implementing of the Yashoda in the hospital is an attempt to meet the mother's needs during and after birth. (7;26)

Srivastava, Kansal, Tiwari, Piang, Chand and Nandan (36) shows that utilization of the governmental services in U.P. is higher among the population from low castes and low socio-economic backgrounds. They also show that a very low percentage utilize all the important

elements of the care. The authors also investigated the satisfaction among the users, with results indicating that 16.3% was not satisfied with the services.

2.3 Identified gaps in the knowledge

Although reports and assessments of the NRHM and JSY exist, (7) essential research on both process and effect of the incentive-based deliveries is still missing. This raises a question of whether a quantitative study should be carried out instead or in addition. First, the size of the change is much too extensive to be quantified in a master's degree thesis. Second, there is also need for qualitative research in this field. Knowledge about the experiences of the women and further understanding of the gap between these experiences and the initial intentions can give important information when evaluating and making new steps in the programs.

Deeper knowledge about the user's thoughts and experiences after an intervention can broaden the understanding of the change and thus contribute a new and important aspect. The aim is to add meaning to the statistics, and to give ideas for further work and planning. After a change like this, it is also an ethical question whether it should be considered important and obvious to raise the voice of the people affected. When plans are made far away from the area of implementation, it is essential to measure how it is received. (32)

In a larger picture, Fretheim and Hviding point out that strong evidence on the gain of facility-based deliveries is lacking. (37) The same authors also claim that no rigorous study has been done to demonstrate that delivering with a skilled birth attendant will reduce mortality on an individual level. They conclude, on the other hand, that such a study may not be ethically acceptable because of the logical arguments in the favor of the facility-based deliveries and the skilled birth attendants.

3.0 Study rationale

The NRHM has brought changes to the Indian health care system. Statistics show that the number of institutional deliveries has increased, (10) but not much is done to investigate the impact or possible consequences seen from the women's perspective. Recent assessments (7) and studies done on quality of care (38) indicate a gap between programmers' intentions and experiences of the users. This study aims to explore this gap. Its main objective is to explore the women's experiences after the recent change, and further to investigate the gap between these experiences and intentions and expectations of policy makers and health care professionals.

When developing strategies for rural India, guidelines are based on broader ideas developed in the international community. Research has shown that to carry out an action in a successful way requires knowledge about realistic possibilities and resources in the field, and adjustments for local differences. (34) Every change may bring expected and unexpected consequences, which again will influence and act on new terms. Hence, as context specific matters may play a role for implementation of new programs, this study aims to broaden the understanding around the recent change from home births toward incentive-based institutional deliveries in Hathras District, U.P.

3.1 Research questions

3.1.1 Interviews with women who had recently given child birth

Women who had recently given birth were interviewed in their homes after discharge from the facility. Qualitative data was gathered from 22 interview-settings, based on a question guide. (Appendix no.1)

Research questions for investigating the women's experiences were formulated as

1. How do the women utilize the local interventions from NRHM, which parts of it do they use and why?
2. How do incentives for institutional delivery affect
 - Their view on pregnancy and childbirth as normal or medical happenings?

- Their understanding of maternal mortality and morbidity?
- Their view on cultural and traditional perspectives in the intra partum period?
- The role and function of the family members?
- Their relation to the health care system?
- Their self-image?
- The empowerment of the women?

3.1.2 Interviews with health officials

As representatives from the policy makers, five health officials were interviewed. These five informants were holding positions at different levels of the programs. The interviews were based on a question guide. (Appendix no.2)

Research questions for the health officials were

1. What are the intentions of NRHM/JSY?
2. How are the programs implemented?
3. What are special challenges?
4. How do they believe NRHM/JSY affect the women in the rural areas (regarding themes listed above)?

3.1.3 Perspectives from the Asia Pacific Midwives' Conference

The researcher's attendance at the Asia Pacific Midwives' Conference (APMC) was an attempt to increase the knowledge on background and ideas that governs work and research on maternal health in India. Information was collected through attendance at selected presentations complemented by discussions with speakers and participants.

Research questions from the APMC were

1. What professional ideas and views influence the planning and implementation of the NRHM/JSY?
2. What is involved in the theoretical perspective of childbirth and midwifery in India?

3. What are the midwives' concerns regarding the change towards institutional deliveries in the rural areas?

3.2 Limitations

India is a country of vast variety. The women in this study were interviewed in one geographical area, namely in Hathras District in Uttar Pradesh. Due to this, and also due to the qualitative nature of methods used, findings from this study cannot be generalized. Findings can to some extent be transferred to other similar settings in India and can be of interest when investigating the same topics in similar contexts. Still, cultural, administrative and political differences will influence both process and outcome of implementations of a program like the NRHM, and thus influence the findings.

The private market for health services in India is rapidly increasing. As this study aims to investigate changes after the introduction of a specific governmental program, the private supply of health services are not taken into consideration other than where it is natural and essential for the context.

The changes towards institutional deliveries are influenced by numerous aspects of changes in Indian society. For this project, the researcher has chosen which parts to emphasize based on the research questions and on the topics relevant for the findings from Hathras. Other topics of current interest like caste, poverty and gender will not be conceptualized or discussed unless natural in the context.

4.0 Methodology and research design

A study's method is decided by its purpose. As this project's purpose was to get an in-depth understanding of peoples' experiences, qualitative methods were the most appropriate. In qualitative research the process is considered as important as the outcome, and the researcher's role is a tool that must be defined and described. (39) Patton (39) suggests the use of "I" in qualitative research, to communicate the inquirer's self-aware role in the inquiry. The researcher's use of "I" can state and support the subjectivity which follows the nature of a qualitative study. It also helps clarifying questions about roles and perceptions when the author's eyes are clearly presented as one of the tools.

Different theories and methods used for the different stages will be elaborated in this chapter. This presents a methodological foundation for the project and shows how it was planned and carried out. Major changes along the way will be elaborated in the discussion of methodology.

The study was based on data from semi-structured interviews and participation at a conference, with opportunistic observations and informal conversations also being sources for background understanding. Statistics already existing gave a foundation for the qualitative approach in the field, and was a part of the larger setting in which the study was conducted.

4.1. Theoretical framework

A theoretical framework is the set of theories and ideas used for a study. (40) This framework will decide how the study is planned, how data are gathered, transcribed and analyzed, and at last which results the researcher presents when the work is completed. The framework is first of all an implement for the working process. It helps the researcher to keep coherence through the different stages in the process, giving a theoretical basis for sorting out and identifying relevant data, as well as for analyzing and writing. (40)

Theories on qualitative inquiries

This study was done with a holistic and inductive approach. A holistic perspective is seeing the person or the phenomenon as a whole, rather than as a composition of its parts. In this lies a focus on the complex interdependencies and dynamics making the synthesis something more than just the sum of its parts. (39) A holistic view was intended through all stages of the project, from planning, approaching the field, gathering data, analyzing and presenting the work. An inductive approach means that the understanding will grow from the individual to

the collective level. The learning comes through investigating specific cases and, from this, learning something about the general. This method is also referred to as “bottom-up”, where we get higher understanding about a topic by using knowledge gained from the specific and individual level. (40) This approach contains a paradox: To be able to understand the informants’ specific experiences, the researcher has to put aside her own understandings, which requires identifying her own theoretical framework and how this will influence the interpretation of the material. At the same time we know that this is not entirely possible. The acknowledgement of this is essential for understanding what the material really tells us. One way of facing this challenge is to use a phenomenological approach to the informants and the material.

Phenomenology was first introduced as a philosophical tradition by Edmund H. Husserl (1859-1938) as the study of how things appear to us and how humans describe their experiences through their own perceptions. As an inspiration for exploratory research it can be used as an attempt to grasp the informants’ experiences and views in a special field. (39) The researcher must then bracket her own presumptions to be open for the view of the other. This requires knowledge and reflections on how our own perceptions will influence the data. Reflexivity, the ongoing examination on what we know and how we know it, is a key concept in this process and is elaborated as a separate point.

Holism and phenomenology form a foundation for exploring phenomena as they occur; the phenomena are seen partly as they are, without interpreting them into a previously known context, but also partly as components in a larger synthesis. Persons’ searching for organizing the experiences in meaningful synthesis can be illustrative when trying to understand their experiences. Kvale and Brinkmann (41) refers to the term “Life World” as the interweave’s lived everyday world, which can be seen as the informants’ platform for their experiences.

Analysis of the material was done in four steps after two approaches described by Patton 2002 (39) and Malterud 2006 (40). Patton refers to Moustaka’s phenomenological model, where the process of analysis is divided in four steps: epoche, phenomenological reduction, imaginative variation and synthesis of texture and structure. Epoche is a Greek word meaning to refrain from judgment. This is the start, where the researcher stays away from her everyday way of perceiving things. Here she looks inside to become aware of personal involvement and personal bias, to identify and clarify where this influences the data. In the next step, the phenomenological reduction, the researcher “brackets” what was identified in the first step,

trying to see the data in its pure and original form, without the perception of the researcher (herself). The next step is imaginative variation, where the data is “horizontalized”, which means that all data has equal weight. From this it is gathered in meaningful clusters. In the last step, the synthesis of texture and structure, data is integrated and structured to present a synthesis of the meaning and essence of the experiences. (39)

Malterud (40), referring to Giorgi’s phenomenological analysis, presents a model containing most of the same theory as Patton, but with a small variation: Malterud starts the analyzing process with getting an overview, with reading all the transcribed data without marking the details, to get a picture of what the data contains as a whole. Through this stage she also emphasizes the importance of identifying our preconceptions and personal involvements to eliminate bias. To start out with getting an overview can result in two things. Either the researcher gets an overview for the rest of the work, a start for the analysis process and a knob on which to hang the further understanding. The other possible result is to start out with getting all preconceptions and prejudices confirmed right from the start, which will make it very difficult to work with an open mind. I believed that with consciousness around this potential problem I would benefit from the advantages of getting an overview.

Professional standpoint

Current knowledge and theories in the subject were also a part of the theoretical framework, and this again was interpreted through my personal and professional standpoint. The theories of Skilled Birth Attendants (SBA) and Emergency Obstetric Care (EmOC) are considered key factors for reducing the maternal mortality globally, (4) and they were chosen to be a part of the frame for this study due to their position in current research. However, with research and evidence-based medicine being subject to rapid and constant change, the theories must also be viewed critically. My personal experience, as a midwife with special interest in natural birth, has influenced the material in different ways. This will be elaborated in the chapter on reflexivity.

4.2 Study site

The interviews with the women who had newly delivered were carried out in the Hathras District, India. Planning, observation and informal conversations were done in the town of Mursan and the nearby cities of Hathras, Mathura and Aligarh, and also through attendance at clinics and camps in the district’s villages by the Methodist Public Health Center (MPHC).

Women were recruited from the Primary Health Center (PHC) in Mursan. This facility was one of five PHCs in the Hathras District. As a governmental institution it offered delivery services around the clock with Skilled Birth Attendance and Emergency Obstetric Care. A doctor was present till 2 pm, after which time deliveries were conducted by midwives. For advanced obstetric care the woman must be referred to the district hospital in Hathras. When referred to in this paper, this PHC in Mursan will be mentioned in terms as the primary health center (PHC), the institution, the facility and the hospital.

The health officials included in the study were interviewed in different geographical areas, one in the Hathras District and four in New Delhi.

The Asia Pacific Midwives Conference (APMC) was held in Hyderabad, the capital city of the southern Indian state of Andhra Pradesh.

4.3 Study population

4.3.1 Women who had recently given birth

To get information about the women's experiences after the changes toward institutional deliveries, women who had recently given birth at the PHC in Mursan were recruited as informants. The women were living in Mursan or the surrounding villages. The majority of them were housewives and, due to local custom, many of them originated from other areas and had moved into the in-laws after marriage. The households involved, without exceptions, extended families, with the grandparent-generation living together with their sons and daughters-in-law, any great grandparents still alive, unmarried daughters and sometimes also daughters who had become widows at a young age. Female family members participated in the interviews to varying degrees.

4.3.2 Health officials

To get an understanding from the authorities and policy-makers, five health officials from different levels were interviewed for this study. One of them was the chief doctor at one of the PHCs in the Hathras District, responsible for implementation of the NRHM services at the very local level. The second and third were from the Ministry of Health and Family Welfare in Delhi. Of these, one of them was a consultant holding special competence and experience in the planning and implementation of JSY for the central government. The other was a consultant with shorter time of service in the ministry, but with long experience from work with reproductive health in rural areas. The fourth and fifth were representatives from the

Norway India Partnership Initiative (NIPI)'s central office in New Delhi. To possibly identify different views within NIPI, one Norwegian and one Indian representative were selected for the study. Of the five persons, two were females and three were males.

4.3.3 The Asia Pacific Midwives' Conference

The Asia Pacific Midwives' Conference (APMC) was organized by the Society of Midwives, India (SOMI). The conference had more than 500 participants, and countries from all continents were represented. Here midwives, gynecologists and other stakeholders shared their views through speeches, lectures, seminars/discussions and workshops. The objective of the conference, from the organizers' perspective, was presented in three parts:

- Exchange information and skills for providing high quality services to women, babies and families.
- Learn from experiences of associations in shaping and strengthening midwifery profession in different countries
- Share a vision and formulate actions for equitable access to services for women and their babies.

4.4 Sampling

Sampling of a specific target group to give an in-depth understanding of a special case or phenomenon is called purposeful sampling. In a qualitative study the aim is not to get a result sufficient to generalize, but to get in-depth information about special cases. (39)

Women who had recently delivered in a governmental institution

The main target was women who had given birth at a governmental institution for incentives, and who also had delivered at home previously, with different types of assistance. Twenty-four women were initially recruited for the study. Of these, 13 had a history of earlier home delivery. Additionally 11 women who had not experienced a previous home-delivery were interviewed: three of these gave birth for the first time, while eight had previously delivered in an institution. Participants had to be 18 years or older to be included in the study.

The women were recruited through records from the PHC (22 women) and through the snowball method (two women). They were visited in their homes after discharge from the facility, and they were given an explanation about the study and invited to participate. They were also given the option that we could come back for the interview another day, irrespective

of sampling method. All 24 women asked agreed to participate and to do the interview right away.

Of the 24 women (and their female relatives) who were interviewed, two of them were excluded from the study after the interview because of former child delivery at the MPHC. This was an exclusion criterion for participating in the study, due to risk of biasing the information because of the team's affiliation with the MPHC.

Inclusion of female relatives

Initially the aim was to conduct private interviews with the women who had recently delivered. From the first interviews, however, we saw that in spite of our attempt to talk with the mothers in privacy, the female relatives remained present for the conversation. The cultural norm was such that the mother-in-law was the decision maker in subjects regarding women's health. It was unnatural and difficult to insist on talking with the new mother in privacy in the family's home; it would put the mother in an uncomfortable and possibly dangerous position. It could also affect the data; the women would act reserved if they were scared that the relatives would listen outside. If the interviews were conducted another place, where the woman could be alone, this situation would be different and thus probably give richer information. On the other hand, it was common among the mothers that they did not go out much, they were housewives and they stayed close to the home, so recruitment for this would be a challenge. After recent child delivery they were also particularly vulnerable, and it was considered important to interview them a place they were comfortable. The subject of the women being a vulnerable group is elaborated under the ethical considerations. The initial obstacle with the female relatives not willing to leave the conversation was utilized as a resource to get extended information. When they also were invited to participate in the interview, the conversations were more easy and natural. Especially supplements from the mother in-laws gave information from another generation and another time, which gives the current changes and experiences a larger perspective.

Health officials

Health officials were sampled purposefully to represent views from authorities and were selected based on their positions. To collect different perspectives within the group of officials, informants with different positions were recruited.

Attendance at the Asia Pacific Midwife Conference

Attendance at the APMC gave access to a midwives' perspective on the subject. The researcher selected relevant presentations and approached speakers and participants for discussions and informal conversations.

4.5 Timeframe

This study was conducted within the frames of the Master of Philosophy degree in International Community Health at the University of Oslo (UiO). In April 2009 an abstract was submitted followed by a literature presentation at the University. Research protocol was submitted to the UiO May 25, 2009. The project was approved by the Regional Ethical Committee (REK) in Norway in June 2009.

The fieldwork in India took place from August 31- December 09, 2009. While waiting for local ethical clearance observation was done, and then the study was commenced after clearance was received on October 14, 2009. Interviews were conducted during the period October 20- December 04, 2009.

4.6 Data collection strategies

4.6.1 Observation and informal conversations

The first six weeks of field work were used for exploring the new culture. This was done through informal conversations and opportunistic observation³, where information was collected and written down in a diary. My contacts in the community and at the MPHC were of great importance to gain access to the society. I learned about everyday life, culture and health care by spending time in the clinic at their health center and by going out on health camps in the villages. Also guided walks gave an introduction to the place seen through the locals' eyes. Further, visits to governmental hospitals allowed informal conversations with women giving birth, midwives, doctors and assistants.

Informal conversations were also conducted at the Ministry of Health and Family Welfare with employees from different departments.

³ Observation in this relation refers to the everyday use of the word, therefore the term "opportunistic". It must not be mistaken for observation as ethnographic method of qualitative inquiry.

4.6.2 Semi-structured interviews

The word interview literally means "inter view", where the interaction between the interviewer and the subject, and the knowledge constructed there, is the essence. It can also be seen as an "inter-change of views between two persons conversing about a theme of mutual interest", where the interviewer follows up answers and asks for details and elaboration. (41) In this way the interview is not a conversation between two equal partners; the power structure occurring when the researcher has the power to control the dialogue with questions and turns can make the interview a one-way session. An interview can be seen as holding two aspects. The first is the relationship between the two parties and the second is the knowledge this relationship yields. (41)

For interviews with both mothers and health officials, the conversation was based on a question guide with open ended questions. The aim was to get information and a description of the life world of the informants, and how they saw and experienced the recent change with the JSY. Their views and experiences would include aspects of life other than just child birth, and understanding their life circumstances was important when trying to grasp their understanding of how things were related. The aim was to collect personal stories in order investigate how the informants saw their situations, and why certain issues were important to them.

All the informants were interviewed once. The interviews lasted from 15- 75 minutes. A tape recorder was used in all settings except from at the interviews at the Ministry of Health and Family Welfare.

Interviews with women

The interviews with the women were conducted in the informants' homes. The physical setting was aimed to form a triangle, where the mother, the interpreter and the interviewer were seated so we could all see each other. Other female family members participating were taking seats around in the room, subject to limitations of space and furniture.

After clarification around participating in the interview, the conversation continued with the translator reading through the Informed Consent Form. (Appendix no.3) Possible questions around this were answered and the informant gave her consent with written signature (12 women) or thumb print (ten women).

Interviews with health officials

The health officials were visited in their offices. The interview with the chief doctor at the PHC was carried out partly in English and partly with a Hindi translator. The translator was one of the male assistants from the Methodist Public Health Center. The interviews at the Ministry of Health and Family Welfare were conducted in English. At the NIPI office, the interview with the Indian representative was done in English, while the interview with the Norwegian representative was done in Norwegian.

4.6.3 Other sources of data

The Asia Pacific Midwives' Conference was a four days conference with speeches, lectures and workshops on midwifery and reproductive health. Participation at this event gave the researcher access to information from the midwives' perspective, and to what is stirring in the specialist environment both regarding research and procedures for clinical work. The researcher participated as one of many international delegates. Learnings and impressions were taken down through hand written notes. Several of the speakers were contacted afterwards for elaboration, both at the conference and through later correspondence.

4.7 Research assistants

The work of this project made use of different types of assistants. Most of the interviews were conducted with an interpreter, and other assistants also accompanied the researcher when and where it was convenient or considered culturally appropriate.

4.7.1 Translator

Because of the lack of formal education, the English language skills of the women to be interviewed in the Hathras District were anticipated to be poor. So as the researcher had no knowledge of Hindi, the work was planned to be implemented with assistance from a local translator. The importance of using a female translator for the interviews with the women was stated from the planning of the study. It was also preferable to have a translator without connection to any of the local hospitals in order to avoid bias.

The process of finding a translator

First, a female translator was expected to be necessary for gaining access to conversations with women in privacy. I expected the cultural code would prohibit women talking with unknown men; and with me also being a stranger; I anticipated a female translator would be more appropriate. The topics for the conversation were of sensitive character, and the women

were likely not to be open with an unknown man present, if they would talk at all. My local contacts in the field were highly educated professionals in the field of interest, and they advised me against looking for a female interpreter. This was for different reasons: Firstly, they did not see the necessity in it; they could not see how the sex of my assistant would interfere with either process or findings for the study. With a parallel to the health care system, where male and female doctors both work with gynecology and obstetrics, they did not expect the women to experience a conversation differently than an examination in this regard. Secondly, they did not expect me to find any female interpreter available in the area. Based on my ideas as a researcher, but also on my world view as a Norwegian nurse, midwife and woman, I decided not to follow their advice and started looking for a female interpreter.

After ethical clearance was received, inquiries were made and an advertisement for a female English-speaking person was placed in the district newspaper. The area has primary schools, with teachers whom could be relevant for the case, but it turned out that all teachers were men. The searching in all gave two interviews with young women from Mursan and several phone calls from women from other places. The local women did not have sufficient language skills for the purpose, and the women calling from surrounding places were staying too far away to make it practically possible.

The MPHC had three English speaking women among their Indian staff. With the absence of women from outside with language skills, and with my set time frame, the option was to start the interviews with the help of these women. Two of them were ANMs, originally from another state but they had been living five and ten years in the local community. The third was a nurse originating from Mursan. All three agreed to translate, and from practical considerations they would alternate according to their shifts at the MPHC. They were paid 300 rupees (40 NOK) per interview.

The translators influence on the material

Using the nurses from MPHC as translators could affect the interviews in different ways. The three of them were all local and knew the area geographically. Working as nurses and midwives they also knew the topic of conversation, which was to be both a resource and a challenge in the interview setting. They would understand the themes and be able to clarify uncertainties, but there was also the danger of them interpreting through their own perceptions and opinions. To prevent this we had conversations before starting, about interpreting as a subject and a skill, and about how our own perceptions will color the understanding of what

we hear from the informant. After I had stayed with them at the center for six weeks we already knew each other, and this made communication easier. The fact that there were three of them was used as a resource. We had group conversations and they could also talk without me present, discussing their task with each other.

All three were persons inviting trust and confidence. In the interview setting, they were initially introduced as the translator. Many of the village women asked more about who they were and what they did, and when telling they were nurses at the missionary center, the women seemed to appreciate their presence. Informants that had previously delivered children at the MPHC, or would have other connections to the center, were excluded from the study to make sure the relation did not interfere with the material. General knowledge of the center was not an exclusion criterion.

Only the translator originating from Mursan had Hindi as her mother tongue, and she had English as her second language. The others, who came from another state and had Hindi as second language, had English as their third language. All material was first transcribed by the researcher, from tape-recorder to written form. Later it was re-transcribed with assistance from another Hindi-speaking interpreter who had higher competence in English. It then turned out that the first translation was limited, resulting in misconceptions in the conversation and missed opportunities of probing.

4.7.2 The need for a male assistant

According to local customs, some of the villages were not considered appropriate or safe for two women to visit alone, and the role of a male assistant was included. The male assistant was also selected from the staff at the MPHC, and three different men were included in the team, alternating according to their working schedule. They were taking the lead when searching the villages and the houses, and they did the practical arrangements in villages where these were needed. To utilize the potential of having a man in the team, the male assistant made a conversation with the male family members in a separate place, while the translator and inquirer were talking with the women. Hence, in addition to obtaining privacy for the women, knowledge from the male perspective was also gathered. The assistant had a guide with three core questions for the conversation written on paper:

- Where should child births take place?
- Is child delivery a topic among you men, or is it an issue only for the women?
- What is the difference between delivering at home or in the hospital?

The assistant made notes with pen and paper. Notes from the conversations were the basis for a later conversation within the team, to increase the knowledge base.

4.8 Reflexivity

Reflexivity is the ongoing process where the researcher investigates his or her influence on the material. With the nature of a qualitative inquiry, where the researcher and his or her frame of reference is a part of the tool, reflexivity is an important part of the systematic critical reflection. (40)

For this project, the researcher was a Norwegian nurse-midwife. The host in India was the Director of a Methodist Public Health Center, owned and supported by the Norwegian Methodist Church. This clinic provided a combination of charity and private health services in a rural area and collaborated with several local governmental projects.

Identifying cultural barriers

During the first period of observation and informal presence in the society it came clear that the cultural differences were too complex to comprehend, and I experienced that my frame of reference differed to an extent I had never experienced. To meet this I first decided to try consciously to identify and let go of my expectations. My Norwegian set of ideas both regarding personal life and medical practice were examined and addressed systematically. I identified local language as a key factor to cultural understanding, both to understand the different concepts and to be able to communicate with the people. While gaining a complete understanding of Hindi in a period of four months is obviously an impossible task, I tried to learn words and phrases to at least come closer. Field notes from this period served several purposes. First, they encouraged the process of formulating thoughts, experiences and emotions in words; this created awareness and helped my own understanding and development. They also worked as a calendar, and helped to maintain an overview over what happened through the days. Third, they were a working tool for my reflexivity, for examining my wishes, prejudices, expectations and defense mechanisms.

Balancing dilemmas

To be a trained nurse midwife from Norway and staying as a researcher at a health clinic in rural India involved different challenging aspects. First, it was obvious that my hands would be needed in the local health care, whereas I came for a different purpose. Second, I had to act in accordance with the local medical practice, which sometimes differed very much from my

medical background. Third, I came from a wealthy country and met a people living under very different conditions. Many of those I met and would interact with would, because of their financial situation, see me as a possible giver or benefactress. Finally, as a stranger I was totally depending on the locals' assistance to be able to do what I had come for. This increased the importance of a good collaboration and the importance of working with these dilemmas in a constructive way.

4.8.1 My role as researcher and nurse-midwife

Patton (39) emphasizes the importance of the researcher separating him or herself from the field, to make reflection possible. To keep up with the processes going on, both for my personal experiences and on the psycho-social or interpersonal level, systematic notes were taken throughout the process. This helped me focus, and helped me to understand what happened in the different areas.

It was a clear strength for me to be a midwife when I came to investigate the women giving birth; my professional background helped me understand many of the factors contributing to the women's experiences. At the same time, my profession created expectations. Since qualitative research is very different from clinical work it was difficult for my surroundings to understand and accept my research, and this was the source of several dilemmas. Some of these problems could possibly have been eased with a clarification of the expectations in the project's planning phase, and this should be considered in future collaborations.

As a Norwegian health professional I am used to medical treatment and care according to a western standard. The procedures in rural India were, as expected, quite different. Initially, as an observer, I decided to consciously let go of my western "critical" view, and tried to understand how things were done and why. I was the visitor on their home ground. At the same time, I could share experiences from my culture, if that was desired in the field. Knowledge and routines in modern medicine are developing and changing rapidly because of research. My knowledge is based on what we do right now, and this might be proven to be wrong later. This supported my idea of being open for other ways of doing things, and I used this opportunity to question my own medical and cultural standpoints. Still, both through clinical observation and in private events I experienced situations where the local custom challenged my professional integrity to such an extent that I had to set a limit for what I could participate in. In these situations I tried to look for other available solutions and navigate within the possible options.

To open up for the new culture would also be essential when trying to understand the perspective of the informants, and to increase the general knowledge on the related subjects.

4.8.2 Staying at the Methodist Public Health Center

The MPHC is owned and supported by the Norwegian Methodist Church. The Director is a Norwegian missionary and nurse-midwife who has been living in the area for more than 30 years. She keeps close contact to Norway through different medical projects, among them having visiting medical students from Rikshospitalet, Oslo. This was the first time a master student was coming for a qualitative research project. She was my host and field work contact, but without responsibility or academic influence on the study. Payment for board and lodging, 1000 INR a day (=3760 NOK per month), was charged from the research budget.

MPHC has been in a transition over the last years regarding child delivery. Being a private institution, the number of women coming to give birth in their facility has decreased noticeably after the introduction of the JSY. From this my hosts had a personal involvement in the subject of the increasing number of women delivering at the governmental institution, and this made it of great importance to sort out possible factors influencing both process and findings for the study. For clarification, the influence was divided in two main categories: direct and indirect influence.

Direct influence: Admission and access

The direct influence involved admission to the field and access to material. The Director and her staff worked inestimably as door openers for both admissions and access. From the start of the study, their relations with local authorities were crucial for getting local permissions and ethical clearance: Permission from Chief Medical Officer (CMO), admission to the ethical committee at the University Hospital in Aligarh and entrance to the governmental institutions in Hathras (District Hospital) and the PHC in Mursan were all received with their assistance. Secondly, interpreters and assistants for the interviews conducted in Mursan were also eventually selected from the MPHC staff. A third aspect would be the Director and her staff sharing their local knowledge throughout the period.

From this it is obvious that my approach to the field, and then also to the informants in Mursan, was dependent on my relationship to the MPHC. This relationship could possibly have a direct influence on the information the women were giving in the interviews. Their knowledge of the missionary center may have colored their answers in different ways, when they were asked questions about experiences at another hospital: If they wanted to give the

impression that the MPHC was a good place, they might talk negatively about the governmental institution and positively about the MPHC. This possible scenario would be reinforced by the translator being an employee from the same place. Although independency and roles were clarified from the start of the interview settings, the team was probably highly associated with the MPHC if the women knew of the institution.

Indirect influence: Perception and communication

My hosts had a vital influence on my experiences in India. Already from planning the trip, a picture of the field appeared through their presentation, through information sent to Norway through mail and correspondence. This was deliberately compared to literature on the subject and information from other sources holding knowledge on the subject. From the start I worked consciously on my new knowledge, with focus on how and why I learned what I learned. Histories told and knowledge shared were perceived through awareness of who told the story and why it was told, and further how I understood it, and why. Awareness on how their influence affected me was of great importance when trying to keep a professional distance to the field. This was a challenge following me through the whole period of planning, data collection and analysis.

The awareness of professional distance had practical implications. When working with the material, I was careful with how I discussed the findings with my hosts. This was due to several reasons. First, confidentiality and the obligation to maintain secrecy to the women interviewed was decisive. This is discussed as a separate subject under ethical considerations. Second, I knew that my hosts' thoughts and opinions would affect my understanding, and then also my further analysis. The fact that they could be seen as a competing institution, having lost the major part of childbirths to governmental institutions through the current change, made this a matter of importance. When I discussed related topics with them, I was deliberate to talk in general terms, and not revealing important or specific findings from the interviews for them to comment on. At the same time they represented a great opportunity for discussing the findings in a local setting. This required that I verbally covered the information and transformed it into more general terms, to make it possible to discuss the findings in the local understanding.

4.9 Data analysis

4.9.1 Management of data

After each of the interviews with the women was completed, the mother's name was erased and replaced with a code, "Mother 1-22". ("M1-22") Coded material from interviews and personal information of the informants were kept in separate, secure places. In the field, the code key was saved on a USB, locked in a suitcase which again was kept in a locked room. When returning to Norway the USB was placed in a safe.

The health officials were interviewed due to their unique positions, so full anonymity was neither possible nor a target. Material from these interviews was attached to the names through the working process, and then, when writing the thesis, their names were removed and replaced by a code, "Health official 1-5" ("HO1-5").

4.9.2 Transcription

All the interviews were tape-recorded. Transcription of the material was done in two steps: first it was done by the researcher, typed word-for-word on a personal computer from the tape. This was done as soon as possible after the interview. With this part of transcription done when still in the field, it afforded the possibility of adjusting the interview guide and the approach to the informants along the way. Given the limited time frame, this benefit was made use of only to a very limited extent. Still it gave several important inputs as the work continued. Some questions from the question guide, such as where the informants wanted to deliver if they ever had another child, and whether they knew where the incentive-payment came from, were abandoned after listening to interviews and experiencing that the questions generated more confusion than quality information.

Second, at a later stage, the material was re-transcribed, assisted by another interpreter fluent in Hindi and English. Here errors were identified and corrected. All transcription from Hindi to English was completed in the field.

Transcription of the interviews of the health officials was done by the researcher. The conversations were recorded, except from with the representatives from Ministry of Health and Family Welfare, where data was noted with pen and paper. The interview with the Norwegian NIPi employee was done in Norwegian, since researcher and informant shared Norwegian as their first language. Material from this interview was coded in the English

themes together with data from the other interviews, and phrases used for quotations were translated to English by the researcher.

4.9.3 Steps of analysis

Analysis was done in four steps according to models from Patton (39) and Malterud (40) described in the theoretical framework. The first step, getting an overview of the data, started while transcribing in the field. Still, when reading through the transcribed material once back in Norway, an attempt was made to start over with an open mind. This way the material could possibly reveal new aspects of which I had not been aware during the fieldwork. With my own experiences in the field thoroughly identified and narrated in the diary, my personal involvement was addressed and expressed. In the second step my personal involvement was consciously put aside and into “brackets”, and the material was studied again. From here, all the data was considered with equal weight and “horizontalized”. The interviews with the women were read thoroughly and six core themes were identified. Segments and phrases from the interviews were then gathered under the different themes, forming descriptive and meaningful clusters. Interviews with health officials were read separately, after the same procedure, and grouped under three themes. Impressions from the AMPC, based on written notes and course material, were structured in three groups. Coding and grouping were done through cutting and pasting in a word document. The fourth step was to gather a synthesis of meaning and essence from the coded material. This phase was a challenge because of the different types of data sources. To meet this, the meaningful clusters were visualized and clarified through physically cutting and organizing the text on posters/papers of bigger size.

4.10 Discussion of methodology

To be able to say something about the study’s relevance, it is essential to investigate the methods’ impact on the material. To question the methods and how they are used is important through all the steps in the project, and through this we can understand more about what we have found and what it actually means. (40)

4.10.1 Validity

To question validity means to question the truth, the correctness and the strength of what you find. (41) This study gives information on something that happens in several arenas at the same time, and it has a triangular approach to the field. Even though the data is presented and discussed through the research questions from one of the perspectives, the women who had

delivered in Mursan, the triangulation gives valuable information and ensures validity in the sense of a broader understanding. When analyzing and discussing the different perspectives through the women's experiences, the knowledge becomes more nuanced and substantial.

The findings in this project are from a small sample, where the material is gathered from a specific geographical place during a specific time, and cannot be generalized. This is not the aim either, given the nature of a qualitative method. Still, since the subject of study involves a change that has been made also in other parts of India, and research from similar settings shows data that easily can be related to the context of Mursan, there is reason to believe that findings from this study can be of interest and relevance also for other places.

Adjustments required while in the field are discussed in a separate chapter below. With the culture previously unknown to the researcher, it turned out that it was difficult to plan a fully realistic and possible project from Norway. In qualitative research, the process is considered equally important as the outcome, (39) and this way the process of change was included as a part of the project.

A discussion on validity also involves a question of what is truth. (41) In relation to the phenomenological and inductive approach, the individual perception is used to say something about a more common standard. This works on several levels in this study. The experience of truth is a subjective affair, depending on different circumstances. The subjectivity of the informants is visible and discussed in the discussion chapters. The subjectivity of the researcher will inevitably lead to interpretation of the material, and discussion of reflexivity is essential to validate the study.

When writing the paper, the discussion was structured after the findings according to the research questions from the interviews with the women. With this structure it is more visible to what extent the objectives are met. The discussion aims to give answers to the questions asked, and some of them are more extensively elaborated on than others. This is mainly based on the material available from the interviews, but also on what is considered relevant and interesting from the researcher's point of view.

4.10.2 Change of focus: Planning and implementation

From the planning phase, the initial objective for this project was to investigate the women's experiences, and to learn about the changes toward hospital deliveries from their point of view. I was aware that the cultural differences would make a full and proper understanding

impossible. I still believed in the attempt of trying, and in this as a way of approaching the informants. With my background as a nurse-midwife from a western country, and with experience from talking with women who have recently given birth, I hoped that I would be able to make the women open up for conversations of depth and sincerity. I was aware of the language barrier, and I planned to use a translator. I have experience working with interpreters in Norway, through providing health care for clients of foreign origin, and I considered this part a difficult but manageable obstacle. It turned out that the cultural- and language barrier, and possibly also the setting with the female relatives attending the interviews, made the women quiet and bashful. The result was that the wanted depth was not reached.

As a response to this, the study's objectives were adjusted: when the intended depth in the interviews with the women was not possible to capture, the project was instead broadened. The initial plan was to make conversations with two NIPi representatives as part of the background. Even though the work in U.P. had not started they were considered relevant for the study, since NIPi's work and policy-making are still relevant for the situation in the state. Now the perspective of policy makers was extended with two representatives from the Ministry of Health and Family Welfare and one representative from the local area. These five health officials were working at different levels in the programs, and by adding in-depth interviews with them to the material the changes could be seen in a broader context.

Also the attendance at the Asia Pacific Midwives' Conference was now used actively for gathering of data, to bring in the perspective of midwives and other professionals as a part of the research material.

Maintenance of approach

Even though the perspectives were adjusted and broadened, the researcher attempted to maintain the holistic and inductive approach. Also the phenomenological inspiration, where the aim was to grasp some of the women's world view, was maintained to a certain extent.

Some of the essence in the phenomenology is to acknowledge how we experience things, and how we view everything through our own perceptions and our own understanding. This was clearly illustrated with the work of this project, which highlighted how differently we see things and how differently we experience the world. Our frames of references are sometimes so dissimilar, and approaching new cultures can involve barriers impossible to comprehend.

Other possibilities

When it came clear that the information from the women was more limited than expected, what might have been an adequate substitute would have been to include in-depth interviews with the local midwives. This idea was abandoned because it would have required a new proposal to the ethical committee, and would therefore not be possible within the time available.

4.10.3 Strengths and limitations summary

Strengths

- No information was available saying that this or a similar study was done before, so the knowledge gained will possibly contribute to new knowledge in the field.
- Data from the three different sources (women, health officials and the midwife conference) presented different perspectives and triangulated the material.
- All interviews were done by the researcher herself. This maintained nearness to the field and facilitated flexibility, which made it possible to identify and adjust objectives and research questions along the way.
- This study was done by an independent researcher, which gave the possibility of analyzing and presenting the data independent of circumstances or expectations from outside.

Limitations

- The researcher had no previous experience with the specific culture; this resulted in optimistic planning and unrealistic expectations.
- With lack of network and skills in local language, the researcher was completely dependent on local assistance.
- The data was exposed to bias and possibly limited due to language barriers. It was also possibly biased because of the relation to a private hospital in the area.
- The data collection was limited by time and resources in the field.
- The qualitative design and small sample will not make it possible to generalize data and findings.

4.11 Dissemination of findings

After the thesis is completed and submitted, a presentation of the work will be given with public access at the University. The thesis will later be available in the University's library.

5.0 Ethical considerations

This project was carried out according to the standards stated in the World Medical Association Declaration of Helsinki, (42) the International Ethical Guidelines for Biomedical Research Involving Human Subjects from the Council for International Organizations of Medical Sciences (CIOMS) (43) and the Universal Declaration of the Human Rights. (44) Specific ethical challenges related to this study are identified below.

5.1 Approvals and permissions

5.1.1 Ethical clearance

In June 2009 the project was approved by the Regional Ethical Committee (REK) in Norway. (Appendix no.4) This approval was subject to the condition that it was also approved in an equivalent committee in India.

Due to misleading local information, an application for Indian ethical approval was first given to the District Magistrate in Hathras District. This was not the adequate address and was never considered properly by the receiver. After numerous approaches for getting a response, the attempt was considered unsuccessful and abandoned. In India ethical approvals for medical research are administrated from the ethics committees at the university hospitals. The project was then submitted to the ethical committee at Aligarh Muslim University Hospital. This hospital is located in Hathras' neighboring district Aligarh, and is the nearest institution with academic competence and authority for giving ethical clearance for medical research. Research protocol and application was presented to the committee, and approval was received October 2009. (Appendix no.5)

5.1.2 Other permissions

Permission for approaching the field was applied for and approved by the Chief Medical Officer (CMO) in Hathras. (Appendix no.6) A letter with a short description of the project was submitted, requesting permission to conduct interviews with women who had recently delivered children in the local governmental institution. The chief doctors at the Primary Health Center (PHC) in Mursan and District Hospital in Hathras also allowed for observation in their clinics.

5.2 The Informed Consent

The informed consent represents the security of a subject's voluntariness and demand for information. After the women consented for being interviewed, information about the study was repeated and a signature indicating informed consent was given. The translator read a written page (formulated by the researcher and earlier approved by the ethical committees) about the project and possible consequences for participating, as well as what would happen if they refused to participate and the possibility of withdrawing at any time. After reading this any questions about the study were answered, and consent was given. Of the 22 women interviewed, 12 signed in written form and ten signed with thumb print.

5.3 Confidentiality

The identity of the women was made anonymous. Confidentiality was secured by replacing their names with a code after the interview setting, and coded data was kept separate from contact information. Gathered data, codes and contact information were only available for the researcher and, during the field work, also the assistants/ interpreters. Coded data and their connectors were kept separate in secure places. The code key was saved on a USB, locked in a safe.

The health officials were selected due to their positions. Even though their names are not mentioned in the text, some of the positions are so specific that it is not possible to ensure the anonymity of interviewees. Thus they may be deemed quasi-anonymous. Their names were attached to the material through the working process and replaced by a code when writing the thesis. They were asked after the interview whether they wanted to see the transcription of the interview at a later stage, but they all said that what had been shared was common understanding without need for further censoring.

Questions regarding confidentiality were important at all stages of the project. As a Norwegian health-care worker and researcher I brought my ideas of confidentiality and patient-related ethics. My experience, though, was that in rural India these terms contained and were defined by other values and references. What we in the western world refer to as privacy seemed to be a different thing in this culture. From observations in the clinics I saw that patients came to see the practitioners accompanied by family or friends, and several patients (and then again accompanied by their respective enlarged families) were all together in the rooms, taking part in the discussion of each other's conditions. Another example of the

different practice of confidentiality was the local way of securing benefits for families with low incomes. One local custom in the villages was that families with rights to special help from the government had their names written in big letters on a public wall- for example on the primary school building. This way it was visible for everybody as a mean to ensure the poor families were receiving help according to their rights. My assistants were used to this culture and this way of handling ethics and confidentiality. The Methodist Public Health Center had a special focus on HIV, and so they were used to focusing on professional secrecy. Nevertheless the gaps between their ideas and mine were too big not to be addressed. To keep other employees at the missionary station out of the talk about confidential affairs regarding the informants in the study, we had repeated conversations about ethics and guidelines. I inevitably intended to work after Norwegian principles, while the partners lived and worked according to what was considered good ethics locally. In this dilemma I tried to balance intentions, local adjustment and feasibility. The field of implementation was my assistants' home ground, while I was the stranger. To learn about their ideas and ethical perceptions gave inestimable meaning also for approaching and trying to understand the culture. A main target ethically was not to harm the informants, and the informants expectations would probably coincide with my assistants understanding of good ethics and local custom. Still I had to balance this with values and guidelines from my Norwegian perspective, to maintain an ethical standard accepted also for the international society.

5.4 To work with a vulnerable group

5.4.1 Meeting with the women

The women participating in this research could be defined as a vulnerable group. Many of them had poor or no education, and they stayed in the home most of the time. I also met them in the house of the enlarged family, where they had moved to stay with the husband's relatives. Living as the daughter-in-law seemed to be living in a position subordinate to the husband's parents, and issues regarding reproductive health were decided by the mother-in-law. My informants were not used to someone asking them how they felt about things, and I believe that for many of them it was difficult to understand what I was looking for. Many of them had no or limited experience with meeting foreigners, and interview settings were characterized by an insecure attitude and sometimes attempts to give the "right" answers, if they would talk much at all. As earlier explained, the female relatives were included in the study. The ethical aspect in this calls attention to the limitations created by the circumstances; to force through the plan of getting the woman to talk in privacy could be unpleasant and

possibly dangerous for her. On the other hand, asking her to state her mind in front of the female relatives was like giving her a chance to be heard, and at the same time ruining it by not creating conditions conducive to free speech. To meet this situation, we tried to make a loose and more open conversation where everyone could talk. The data were also analyzed with awareness that the material was gathered in a larger setting, where the meanings of the elderly would dominate the conversation and limit possible nuances.

A woman is also fragile and extremely vulnerable after giving birth, due to a natural mechanism increasing her sensitivity for the baby's signals. (35) Although useful for the attachment to the baby, this sensitivity can be a challenge in other situations and it made the question about voluntariness and consent very important. Several of the women showed emotions through the veil of bashfulness, and in one setting we had to stop the interview and stop the tape recorder to comfort a mother who was grieved after experiencing loss of a relative during pregnancy.

After the interviews ended, the mothers were given a small soap for the baby, as a compensation for their contribution. Local knowledge said that it would be insulting to bring food or something to drink when coming to the house, so a small present for the baby was considered an appropriate solution.

5.4.2 Handling identified injustice

The work with this study revealed one main factor of injustice, the fact that the women were charged in the facilities. Services and medicines in the program for institutional deliveries are supposed to be free of cost, but as presented in the findings, the informants reported to have paid in the institution. When the chief doctor at the PHC was asked about the same subject, he claimed that the women did not pay anything, that everything was free. What can be referred to as corruption is a pervasive phenomenon in India, and Uttar Pradesh is known for being among the worst states. The contradictory information from the interviews clearly identified corruption as a current problem; this was a finding from the interviews and will be presented and discussed among the other themes. One can ask whether I should have confronted the chief doctor in the situation, when he told that everything was free, and say that women had reported fees and charges. This was not done due to several reasons. First, it would imply breaking my promise of secrecy and confidentiality given to the women. Second it would possibly create problems for the employees at the PHC, including making a very unpleasant situation for the chief doctor, both of which would be very inappropriate ways of thanking

them for participating in the study. It would undoubtedly also make problems for my hosts at the MPHC and, not at least, make all parties involved more skeptical to participate in any study like this at a later point. To act on this would neither be the objective of my project, nor would it be an adequate or clever contribution to the combating of injustice and corruption.

5.5 Beneficence and usefulness

A question of practical benefits from this project must be tested in an ethical perspective: While there is a vast need for health care personnel in India, I decided, as a qualified nurse midwife, to go as a researcher instead of using my skills at the local hospital. This question must be seen in a larger setting. The help and services these women are given should be a subject for attention on a higher level, especially attention based on views from their own perspective. In the organizing and changing of the discussed health services, the voice of these women should, and hopefully will, be heard in the international society. This study aimed to contribute this target.

Based on this view, I went to the field with awareness of the dilemma around the role of researcher and qualified health professional, and as health professional I was obliged to help in given situations where it was needed.

6.0 Findings

Findings from the three different sources of information: the 22 women who had recently given birth, the five health officials and the Asia Pacific Midwives' Conference were analyzed separately and are presented in the following chapter. Quotation marks around the informants' code ("Mother/M1-22" and "Health official/HO 1-5") are removed in the presentation.

6.1 Interviews with women

The mothers interviewed were living with their in-law families, and so all the 22 interviews were made with female relatives present and taking part to varying degrees. This group of females varied from only the mother-in-law or a sister-in-law to bigger groups of women, with other female relatives and neighboring women joining the conversation. In one of the interviews an ASHA and a PHC nurse were incidentally available and chose to participate. In the smaller villages, a crowd of people came to see what was going on when we came. The purpose for the visit was then explained, questions were answered and the crowd was then asked to leave to give the mother and the family privacy for the interview.

The mothers were, in general, not very talkative. They answered questions when asked, but often very briefly. They seemed shy and careful in the setting with the relatives present. As fresh mothers they also seemed sensitive and mostly concerned about their new babies, but they were all positive and welcoming to the team when we visited their home.

Core themes

Information from the interviews with the women was structured in seven core themes. Here they are presented in a "chronological" order, from determinants for going to the facility to the reflections afterwards:

- Family structure and function
- Determination factors
- Infrastructure and transport
- Experiences in the institutions
- Financial matters: expenses and incentives
- The gender of the newborn
- Perceptions and thoughts around the change

6.1.1 Family structure and function

All the women interviewed were married and lived in a shared household with the husband's extended family. Informal conversations confirmed that the family was considered a foundation stone in the society and that the common way of entering a marriage was through arrangements done by parents. The core of the extended family in this area normally involved a husband's parents, his brothers and their families, and his sisters, if still unmarried. When they married, the women moved out from their childhood homes to live with the in-law family, many of them from other villages or far away towns. A young woman who had moved to a village from a bigger city explained, when she was asked how she felt about leaving her home: "Whatever is written in your destiny, you have to go there..." (M15)

Child delivery: a family issue

All the informants automatically involved the family when telling about their experiences with the recent delivery; family members decided when and where to go, and they all went together to the hospital. "The family" was also the common answer when questioned about with whom they discussed these issues.

Most of the women went to the facility accompanied by a large group of people. Mother 19 responded, when asked about whom had accompanied her to the hospital: "My husband, sisters-in-law, mother-in law, aunties, father-in-law and some relatives... And ASHA..." Her entourage was representative for the informants, many of whom also included neighbor ladies⁴ taking part in the group.

Support from family was pointed out as important for all the women. Practical tasks, like washing, cooking and looking after the other children, were all reported as a common job for the family in this period. Support from family was considered important also when staying at the hospital. Psycho-social support and providing and serving water and any food was the responsibility of the family. Several of the mothers also said that when staying in the facility overnight, either before or after delivery, the nurse went home to sleep and the relatives were left to take care of them. The nurse would be on call in a nearby house:

The nurse left after some time, and my mother- in-law helped me afterwards. (...) The mother-in-law was staying for the night. The delivery was after one hour, nurse went home, and mother-in-law was staying. (M 22)

⁴ The expression used by the translators, when talking about female neighbors, was "neighbor ladies". This translation is kept in the text in order to keep the authentic description of the social environment.

The mother-in-law of Mother 8, who was not very satisfied with the help they got in the facility, said: “I helped her. What would that old nurse have done alone?”

Mothers-in-law and female relatives were the ones who taught how to breastfeed and how to take care of the newborn. Many of the women who had earlier delivered at home also reported that the mother-in-law had been the one assisting for the delivery.



Female generations in Mursan

Decision making

From spending time in the community, I learned that the oldest man in the family was often considered the general decision maker. Observation at the MPHC showed that men were also involved in health issues: When boys came for healthcare, they were often accompanied by their fathers. Women’s health and reproductive health, on the other hand, seemed to be a female issue. When the girls came to check-ups they came accompanied by the mother-in-law, and often also other women, such as sisters-in-law or neighbor ladies. The mother-in-law was the leading person, the one answering questions, and the mothers themselves seemed quiet and shy in the situation. Some of the mothers had gone to antenatal check-ups during pregnancy, but most of them came only once and mainly for vaccinations.

When the birth started, the mother-in-law seemed to be the main decision maker; most of the mothers interviewed presented their mothers-in-law as the one deciding whether and when to go to the hospital for delivery. This was explained as an area where the women were in charge, and then the elder women were the ones with most experience and respect. The men kept a more secondary position. From a conversation with Mother 9 and her female relatives,

the mother said: “My mother-in-law is more powerful than my husband in the family...” The mother-in-law added: “When I’m deciding something for her benefit, then what would the husband say?”

Men’s role

When asked about men’s role regarding the delivery, many of the women started giggling. They were accompanied by husbands or fathers-in-law to the clinic, but the men were waiting outside. Except for practical arrangements with transportation, men were not reported to have special tasks:

Nothing, what will he do? He was standing outside, waiting for the baby... And after delivery he went back because we have other children at home... (M9)

He helped with transportation... With what else could he help? (M10)

Information from informal conversations between the male assistants and the families’ men, done outside while the interviews took place, told us that men had opinions about the topic. All the men asked said they wanted the women to go to a hospital for delivery. Some of them also said it was good with the incentives given, so the woman could get some proper food after delivery.

6.1.2 Determination factors

There were several reasons mentioned for going to the facility. With the mother-in-law in charge of the situation, different conditions seemed to influence the decisional process, such as motivation from the ASHA, desire or need for safety and medical assistance, hygienic conditions, lack of dais or other assistance in the homes or instructions from community leaders. Further, the idea of this being a new time, with new practices, and fear for what others would say if they acted differently from rest of the village, were also mentioned as reasons for going to the institution.

Motivation from ASHA

Most of the women had been accompanied by the ASHA to the clinic, and influence from her was reported to be a factor for the decision: “The ASHA told us that government PHC is near and very good.” (M8) Mother 16 said: “I didn’t decide myself; it was the ASHA that took me to the hospital (...).” By some of the mothers the ASHA was also referred to as the main decision maker, and as a person having her own agenda: “No, ASHA did not accompany me. But afterwards she reached there. I had so much pain so we didn’t have time to call the

ASHA. We went directly to the hospital.” (M2) Another mother stated: “ASHA is coming because she also gets money. (M18)

Some of the villages introduced the local ASHA to us on their own initiative. The ASHAs seemed proud to have this job, and the women presented them with respect. Many of the women also said, unasked, that the ASHA informed them about different health issues and took them for vaccinations.



ASHA in a one of the villages

Facilities and medical safety

The desire for medical facilities and safety were considered main factors for many of the women:

Mother 4: I thought there might be some problems at home, so I went to hospital not to have any problems while delivering.

Interviewer: Do the money mean much to you for going to the hospital?

Mother 4: I wanted facilities, not 1400 rupees.

Mother 9 said: "I didn't think about anything. My mother-in-law took me to the hospital, because she thinks the hospital is good." Her mother-in-law added:

I took my daughter-in-law to the hospital because I don't want my neighbors and others to talk about me and that I don't take good care of my daughter-in-law, and that I haven't taken her to the hospital. I want my daughter-in-law and her unborn child to be safe.

Lack of assistants and poor hygiene in the home

Lack of assistance or facilities in the homes was also described as decisive:

For this birth I went to the PHC. My mother in-law expired, so I don't have anyone to take care of me at home. But my other babies were delivered at home (...). I decided it myself; there was no one else to take care of me. (M5)

Mother 18: I didn't want that money; I collected it for the child.

Interviewer: It will be useful for the child... Was that why you went to the hospital?

Mother 18: There was no one in the house to help me. My mother-in-law is too old; she could not help me with delivering. And my house is too dirty. It was very good that we went to the hospital, for there was no one to help me. (...) It was ASHA who came and told me right away, that now you should go to the hospital.

Also lack of dais was a mentioned problem: "There is no dai here, so we have to go to the hospital." (M1)

Complications in planned home deliveries

An opposite view was presented from women who had planned home delivery, but had to go to the facility for assistance when it didn't progress as planned. Many of the women would prefer to deliver at home, but went to the institution when they were in trouble. Mother 3 said: "I had heavy bleeding at home..." The relatives added: "When we came back from work we saw that she was bleeding, so we brought her to the hospital. Together with the ASHA (...) We were in trouble, so we went there."

Other examples were Mother 6: "It was because of the difficulty in the labor we went there, not for money." and Mother 12: "I wanted home delivery.(...) I did not go only for money. I was in trouble... The baby was not delivering at home, so then I went to the hospital." Mother 20 also told that she tried home delivery first:

Mother 20: When the baby was not coming, we went to the hospital. (...) I tried at home and it didn't happen. Others who have delivered at hospital asked us to go there; they told it would be good in the hospital. So 1400 rupees is not the only thing. I am not greedy with money. It would have been good if I delivered at home.

Interviewer: Could you decide that yourself?

Mother 20: Mother-in-law decided.

Interviewer: What would you do if you could decide?

Mother 20: I haven't decided anything. I was scared what would happen next.

The idea of a modern time

Many of the women and their relatives described the community as having been through a change during the last years: "All are going to hospitals. Nobody deliver at home these days. In our family, we go to hospital for all deliveries." (M2) Mother 21 said:

Most of us are going to the hospital (...) because of the complications, and now these days the women's bodies are not strong like it used to be earlier. If it's taking less time, then it's ok. But if it's taking more time, 6-7 hours, then hospital is best. If something happens, and we can't transport, then it's better to go before.

The mother-in-law of Mother 9, who explained she wanted facilities and medical safety, also expressed the importance of what others might say in case she didn't "follow the norm" and something then happened.

Other determinants

One mother also mentioned the village leader as the deciding person: "When the pain started, the village chairman decided to go to the hospital." (M11)

None of the informants mentioned or acknowledged the financial incentives as the deciding factor for going, even though many of them were open about their financial situation and addressed themselves as "poor".

6.1.3 Infrastructure and transport

The rural part of Hathras District has varying road quality and a vast variety of transportation methods. Roads have been upgraded during the last decade, but still many of the smaller roads are only graveled and of poor quality. A very small number of the households have access to a car. Other frequently used transportation methods are animals with cart (horse, mule, donkey, ox or buffalo), three-wheeler (so-called "tempo", a small three-wheeled car, often used as a taxi), lorry, tractor, moped or motorcycles and variations of motorized vehicles, where different types of engines have been connected with structural arrangements on wheels. Many people often go together, and fill in passengers in any possible spots: inside the carriage, on the roof and hanging on the truck body. In the towns there are taxi services available, but fuel is relatively expensive in India.

Transport to the facility

Most of the informants had used some kind of transportation method for getting to the facility. The ones who walked did it either because it was very close or because the family had no money to pay for transport. Among the women interviewed, all the earlier mentioned methods of transportation were reported. Some of the villages had a jeep, tempo or a motorized vehicle available for the inhabitants; in other places neighbors and friends were engaged to lend their draught animals and cart.

Transportation to the facility involved varying degree of effort for the women and their group. Mother 1 stated: “No problem. We bring the tractor and go to the hospital.” Most of the women reported the transport to be no matter of problem; they used what was available for them and got to the facility. Mother 18 even believed that her transport experience facilitated progress in the delivery: “I went with horse and cart, and because of the jumps there I delivered fast.”

For others, where transportation was more of a challenge, Mother 2 said:

I went to the road on foot... But there was no tempo, so then we had to walk for another 2 kilometers. We don't have any money; otherwise we would have hired a vehicle. For coming back we hired a horse and cart.

None of the women spoke about the incentives in relation to transport, but several of them said that the ASHA was the one in charge of the trip. As delivering at the PHC was an inclusion criterion for the study, none of the informants experienced a need for transfer transport while in labour, or reported that the lack of transport was a hindrance for getting to the PHC.

6.1.4 Experiences in the institutions

The intention of the JSY is to make safe and skilled delivery a reality for all women giving birth. By making the deliveries happen in the institutions, the women will have access to medicines and proper medical care given by a skilled birth attendant. After delivery women are recommended to stay in the facility for 48 hours to ensure proper care in case complications occur.



Delivery room at the PHC

The Mursan PHC was a brick building, where the delivery ward contained four

rooms. One of the rooms was used for conducting deliveries. This room was around 12 m² and had two benches with feet pointing toward each other at a 45 degree angle. Deliveries were done on both benches, with the female relatives of both women present in the room at the same time.

Good experiences and unspecified satisfaction

Most of the women expressed satisfaction with the experiences in the facilities. All informants said they had got help from one or several nurses for delivery; none of them delivered with assistance from a doctor. When asked about how they found the help they got, the common answer was “good”. When they were asked to specify what was “good”, many of them answered they didn’t know. Other common answers were “good facility” or “everything“. Examples from this were: “Hospitals have the facilities, and that’s good” (M5), “When you are in trouble, everything that helps you seems good” (M19) and “The hospital was very good, was nothing I didn’t like. When you’re alive, everything is good. Nothing matters as long as you get the baby.” (M20)

Medication for normal deliveries: Oxytocin as a welcomed routine

A factor in the clinic described as positive by many of the informants, was the medication given. Mother 5, who had previously given birth two times at home and two times at the PHC, said: “In hospital I got good injections and good tablets, so I could deliver fast. In home, the deliveries are very long, as there are no medicines given (...) “ (M5) Mother 7, who also had experiences from both home and hospital deliveries, said:

It was very good in the hospital. They gave me two injections as my cervix was not fully open, and then afterwards they gave me one injection to increase the pains. And after that I delivered without any problems.

Mother 11 also had experience from both options:

At home, I was not having very strong pain. I don’t like to stay very long time in bed when I have pain... So I went to the hospital and delivered very fast.

Both medicines and support contributed to a good experience for many of the mothers. One mother, now delivering her fifth child after four earlier home deliveries, said: “It was very good in the hospital. I felt less pain compared to home. “(M13). Mother 12, who had delivered once before at the clinic but had not had a home delivery, said: “Nurse helped me there (...) She gave me some injections to increase the pain, so that the delivery could be fast.”

According to information accessible to the researcher (from the women’s stories and patients lists from the clinic), all women interviewed had now been through a normal birth, or, in other words, a birth without complications from a medical perspective. Nevertheless, all women reported to have received either injections or infusions through or after delivery. Many of

them did not know why the medication was given. Mother 21 and 22, both *multi para*, did not know why they got medicines:

Mother 21: It was good, she delivered my child (...) She gave me some injections, maybe five.

Interviewer: Five injections- What was the injections for?

Mother 21: I don't know what it was, she mixed and gave me.

Mother 22: I got two injections before delivery, nothing after the delivery.

Interviewer: What was the injections for, do you know why they gave you injections?

Mother 22: No, I don't know.

Quick delivery and quick return home

Together with the fast deliveries, another trend was that the women returned quickly home afterwards. Mother 11 explained, with a similar story as many of the others: "They gave me injections, and very soon I delivered. I reached there at 7, delivered at 8 and came back at 8.30."

Some of the women also stayed for some hours or overnight if they delivered in the evening: "I stayed all night in the hospital in PHC. 8.30 I went to the hospital and 9 pm I delivered, and then came back in the morning." (M22) "I started at 12, reached there at 1, delivered at 3, and I came home at 10 pm." (M5)

One woman had stayed for the recommended 48 hours; this was because she had an episiotomy and painful stitches.

Other experiences and dissatisfaction in the facilities

Not everyone was satisfied with the service and treatment they got at the PHC. Mother 8 had previously delivered in another hospital, and she and her family were not happy with the help they got this time. Her Mother-in-law reported:

Mother-in-law: In Hathras⁵ there were many people to help us. But here, the only nurse who was present gave her 2 injections and went home. Then we had to call her after she had good contractions, to do the delivery. It was a problem.

Interviewer: So you were much alone?

Mother-in-law: Behenji⁶, I tell you one incident of that day: The only nurse who was present at the delivery, she is very aged now, she broke the cord and placenta was inside the womb. I don't know how my relative survived.

Also Mothers 15 and 18 told about varying experiences in the PHC: "The nurse was very good. First time I delivered in that hospital, the nurse was very bad." (M15) Mother 18 said:

⁵ The city of Hathras is the nearest city with a District Hospital, 20 km from Mursan.

⁶ Behenji is a Hindi expression composed of the word for sister, "behen", and the expression for respect, "ji", often used when approaching a female of your own age.

My delivery was very fast after they gave me injections. And I have heard from other hospitals that the staff shouts at the patients, but here was nothing like that. (...) I went and just lied down and delivered. But one lady was there who was there for the last two hours, and the staff was shouting on her. I felt very bad.

6.1.5 Financial matters: incentives and expenses

The local currency is Indian rupees, and transactions in the society are usually done in cash payment. Observation and informal conversation told me that the importance of money was very visible in the society. The area had a widespread problem of poverty, and many favors, services and interpersonal exchanges seemed to be valued by a prize. Bargaining was a general rule in all trade, and most transactions seemed to be done quicker if an unofficial “transaction fee” was paid. In informal conversations in the community I was told that fees and charges were widespread also among the employees in the governmental health care system: workers at different levels often had to pay people at the level above them for keeping good working conditions or attaining special positions.

At the nearby private hospital, the price for an uncomplicated delivery was 1500 rupees. In the governmental institutions, all services and medicines are supposed to be free under the JSY program.

Costs in the facility

Most of the informants reported that they had been charged for the services in the governmental facility. The cost for admission, charged by the nurses, varied from 300-700 rupees. They also reported to have spent money on services from sweepers and cleaners:

The nurses took 350 rupees. And one sweeper took 50 rupees. And one clean-boy also took 100 rupees. My relatives were not very clever, so whatever they asked, they paid. (M2)

Medicines were an additional expense. Many of the informants reported to have either been charged for medication in the facility, or they got prescriptions for medicines they had to purchase from the outside: “The nurses took 350 rupees. And she had written some medicine that I had to buy from the outside, costing 400 rupees.” (M1) Other examples were: “I got some injections, 4 types of tablets...(…) The nurse gave me so much medicines, I think that is why I had to pay money.” (M11), “I paid 500-600 rupees for the medicine. And 250 to sweepers.” (M19) and “700 rupees I paid to the nurse, and after delivery I bought some medicines from the outside.” (M20)

Some of the informants showed awareness around the calculation of expenses. Mother 13 said that she would have preferred a home delivery, but she had to go to the facility for medical help:

Why not home delivery? It is so troublesome to get there and come back. I almost spend 1400 rupees. 500 I gave there, and for travel expenses I spent 500 also. So it would have been better if I delivered at home. (M13)

Expenses in the facility were reported to be a hampering factor for attending the services:

First you need money to give to the nurses... My husband's brother's wife didn't have any money so the doctor pushed her out of the hospital in Hathras, then she died at home (...) First they pay, and afterwards they get the 1400 rupees. I had saved some money at home, so I took that money and used that. (M3)

The same mother claimed that the expenses still made some of the women deliver at home: "Very poor patients deliver at home with the help of a dai in this village" (M3)

Another mother stated that the system was not working how it was supposed to:

This hospital started deliveries 3-4 years ago, and they are taking the money before the delivery and then they give us prescription paper with which medicines to buy from the market. Government is sending much more money, but this people at the PHC are not paying us. (M22)

Few of the women said they had not been charged in the facility. One of them was interviewed with a nurse from the PHC present in the room (M16). The nurse was in the village coincidentally to give vaccinations, and she joined into the conversation together with the group of female relatives and a neighbor. When the question of expenses in the facilities was raised, the nurse told the mother to say she didn't pay:

Nurse: Tell them you didn't pay anything

Mother 16: I bought some medicines from the medical stores... But not money

Another mother, who was not charged, was a poor woman whose husband had been seriously wounded in an accident some time ago. When asked, she replied: "They didn't ask for any money. If they would have asked, I wouldn't have any money to give them." (M21)

Money check as method of payment

Before discharge from the facility, the women got their check worth 1400 rupees. Some of the women had not gotten the check yet because they had been in the facility only at nighttime or during festivals; and they would have to come back to collect the check. Some of the informants did not know what to do about this: "Till now we haven't got anything... But in one or two days we will get a check, we hope" (M11)." We are so poor... I think we should

have collected some money to help, but ... We got a check, but till now we didn't get any money" (M2).

6.1.6 The gender of the new baby

The baby's sex seemed to be important for the women, and some of them reported that getting a boy or a girl affected the experience of being a mother and the experiences in the facility.

Mother 2, when asked about whether she had any problems at the hospital, replied: "No. I delivered, and I born a male baby."

Several of the women presented the desire for male babies as a reason for having many children. Mother 13 said: "After four girls, this is the lucky boy. I am happy." Other phrases were:

We want one more boy... If you go to get your girl married, the in-laws will ask about the brothers of the girl. So the boys are important. (M11)

Because of the family name... To get boys we had so many girls, because boys carry the family name to the next generation. Four girls and one boy. Without boys, how will our name be carried to the next generation? (M22)

Of the 22 mothers included in the study, ten of them delivered girls and 12 delivered boys. When analyzing the material, no direct connection was seen between the sex of the baby and the satisfaction of the mother. Of the three mothers reporting negative experiences in the facility, two of them had delivered sons.

From one of the mothers who had delivered a girl baby, and who already had daughters, it was stated that the government should support them additionally in this situation: "We have so many girls, so government should help us." (M22)

6.1.7 Perception and thoughts on hospital and home delivery

The change towards hospital deliveries was described as a factor in a "new time", where different parts formed a compound change in the society. From informal conversations in the community, I also learned that for many of the mothers coming to hospital for delivery, this would be their first meeting with the healthcare system. Hospital treatment was viewed as mainly a thing for very sick people, and generally they did not go there if they did not have to.

Home vs. hospital delivery

Most of the women expressed satisfaction with the facilities. Still they expressed varying opinions regarding the difference between institutional deliveries and home births. Some said

they saw no significant difference, and they went to the PHC only because they were told to go. Mother 21 said:

There is no difference between hospital and home deliveries (...) In hospital, when I delivered, I was sitting down on the floor, not lying in bed. At home I also do the same. So there is no difference (...) I would like to stay at home, but the ASHA took me there. I didn't have any problems.

Other informants had an opposite view. The mother-in-law of Mother 10 said:

There is development in every field. Now hospitals are very much developed (...) We went to the hospital because of the facilities... I don't worry about the money; I want mother and child to be safe."

She also told that she had delivered twice in hospital, in her time, and that both of those children died. The rest of her children were born at home, and they were fine. She said she was very scared of hospital instruments and did not like hospitals at all. Still she wanted her daughter-in-law to have a hospital delivery, because of the improvements that had been since then.

Also the mother-in-law of Mother 15 said that she had lost children, but after home deliveries: "At my time I hadn't heard about hospitals. I delivered four babies at home. Two of my girls died, and one boy also died after delivery." She talked about now as a different time, and that the delivery practice had changed:

At that time, we used to do a lot of work at home. Nowadays, with these new women, they lie down on the bed and they don't work in the pregnancy. So these days they can't deliver at home, so we have to go to the hospital. For my concern, I liked home deliveries. (Mother-in-law of Mother 15)

Many of the mothers themselves found hospital delivery different from home delivery. Mother 11 emphasized both medical practices and hygiene as important dissimilarities. She demonstrated a squatting position and said: "In home delivery you sit on a brick, do you understand? Very bad hygiene (...) Hygiene is very good in hospital."

Another mother with clear statements for the importance of going to the hospital was Mother 19. She said that there had been a change 2-3 years ago. In older times the women were delivering at home, but the "new girls" went to the hospital. She said that facilities, medicines and support from the people there were important factors. She continued:

We are getting money now, but earlier there were no money. But we still used to go to the hospital. (...) When you are in trouble, everything that helps you seems good. (M19)

Some of the mothers also pointed to severe cases and bad experiences as reasons for the change of practice. Mother 3 said that after her sister-in-law died while delivering at home,

they decided that everyone should go to the hospital. Mother 22, a woman who had delivered four children and tried both home and hospital, had a strong view: "When delivering in the village, half of the women die. In hospital, in case of emergency, doctors and other staff will be available to help.". When asked about whether she believed the 1400 rupees had been a part of the change, she said:

This is not the only cause. Delivering at home can take the life of the mother. We go to hospital for safe deliveries (...) some people are very poor. 1400 rupees after delivery makes that she can buy good food also. (M22)

Views on Traditional Birth Attendants

All the informants were asked to share their view on traditional birth attendants. According to the women, the dais in the area were a diverse group with varying skills. Some of them came to deliver the baby, but many of them were called for only after the baby was born: their job was then to cut the cord, deliver the placenta and give the baby a bath. Both from the interviews and from informal conversations in the community I learned that this part was considered a "dirty" work, and was therefore left to women from the lower caste, who often otherwise were employed as sweepers. In these cases the mother-in-law or other female relatives helped with the delivery of the child, and then the dai came afterwards.

The "new time" also involved changes for the dais, according to the mothers: "Nowadays dais refuse. They can't do deliveries, there can be some problems. So most of the women go to the hospital." (M4). Knowledge, practices and hygiene of the dais were problematic areas, according to several of the mothers. Mother 14 said:

There are very few home deliveries these days. Now these new dais don't have much knowledge. They say it will be difficult to deliver at home; we will not be able to do it. They also put unclean hands inside the womb, so that is not good.

Birth as a natural happening

The delivery of the child was also, by some of the informants, referred to as a natural event with no need for special support. One mother answered, when asked who was assisting in her previous home birth: "No one, only God was assisting." (M21) Her relatives added: "No need for assistance, it comes out on its own".

Awareness and sharing of information

When asked whom they talked with about the changes, most of the mothers said they did not talk with anyone, or that they talked only in the family. Many of them also said they did not go out much; they were housewives and stayed at home. For some of the families it was not

considered culturally acceptable that daughters-in-law were out in the community. Especially after delivery they stayed in the home for some time. Some presented a view of the women being “dirty” after delivery, and for that reason they were especially isolated for a period. Now, when our team came to visit the house, it seemed to attract a lot of attention. Several of the mothers said explicitly that all the people now came because of the visitors (the team), and that since they got home from the hospital and till now, they had not seen anyone except family.

Even though many of the women said they did not talk much about the changes, or only within the family, there were different sources for information mentioned. The ASHA was a common source; she informed about the need for and availability of vaccines and hospital deliveries. She also informed about the incentives and encouraged the women to utilize the services. She was referred to with enthusiasm and respect.

Trust in authorities and health personnel

There were also other types of health personnel reaching out to the villages. Mother 8 said:

In hospital these days, there are good facilities and good work... There are no facilities in the villages. There was a doctor here in our village, and a team was with him, and he told us that all the deliveries should go to the government hospital, because at home the dais don't use gloves, and there are so many diseases these days that can be transmitted to others by not wearing gloves.

Some of the women showed interest in the societal changes on several levels. The Chief Minister in Uttar Pradesh, Kumari Mayawati, and her strict governance, was referred to as a reason for the improvement (M21). Still they said they thought the government should do more for poor people, and that it was difficult to get a job. It was stated that very poor people had to deliver at home because they could not pay the hospital or for transport, and in that case it did not help to get money afterwards. Also education was mentioned as a factor for choices regarding health, and that illiterate women were more likely to have home deliveries.

6.2 Interviews with health officials

Information from the five health officials was gathered when visiting in their respective offices in Delhi/Hathras. They were asked about official policies and intentions as well as their own opinions about the change towards institutional deliveries. Information from the interviews was gathered in three core themes:

- Intentions and implementation of the JSY/NRHM

- Positive indicators
- Challenges

6.2.1 Intentions and implementation of the JSY/NRHM

The informants had a collective view around the main intentions of the programs: the overall goal for JSY is to contribute to a reduction in the MMR in India. Previously an economic barrier has been preventing many women from going to the hospital, but now money is given to cover the expenses. Hence, incentives for institutional delivery will make safe motherhood a possibility for all, regardless of financial circumstances. The increasing number of deliveries will again put pressure on the supply-side, and so further improvements will come. The officials working from Delhi emphasized that JSY is a two-step program: The first thing is to make the women come. Then, secondly, there will be improvement of facilities and services. As one of them said, "The first three years are only about numbers, and then we push for quality". (HO3)

Organization

The representatives from the Ministry of Health and Family Welfare talked about health as a state subject: The main guidelines come from Delhi, but the states have freedom and responsibility to plan and spend the money. With the JSY there is also an "unlimited" account for deliveries. (HO2) An aim is to have full transparency at all levels, so all reports are available online for everyone to read. (HO1-4)

Strategic thinking

The JSY program is planned to last until 2012, and all the informants believed it would be prolonged. A timeline of ten years was considered a realistic frame for improvements and creating sustainability. Behavioral change takes time. The long-time target is to create awareness, to make the women utilize the government services and then make it sustainable. They told that for many women, this will be the first meeting with the hospital. JSY will be a door-opener for reaching them, for giving them treatment and care and making them want to come back. This was also believed to influence other aspects of health, since they will be more likely to seek help from a place they already know if the experiences there have been good.

Even though institutional deliveries are the overall strategy in NRHM, the informants said that home deliveries are also still encouraged, as long as the birth attendant is skilled. JSY

even includes incentives for home deliveries assisted by a skilled attendant, with 500 rupees paid as the incentive. (HO3)

Neither the official policies nor the informants themselves contemplated a role in the program for TBAs. The informants said that home deliveries assisted by TBAs still take place, but it is not encouraged or recommended. When asked about whether they believed the TBAs could be of any resource in the new programs, none of them did. TBAs were considered a part of the history, and a part of the culture, but were not to play a part in modern obstetrics.

The thought that a hospital is only for very sick people was also said to be widespread. What one of the informants referred to as “strong tradition of old beliefs and prejudices” can hinder people in getting proper treatment. A suggested way of approaching this was to investigate and increase knowledge about how the public view things. (HO2)

Another possible strategy mentioned by the informants was collaborating with the private market. (HO1)

Facilities and services

A main practical concern among the informants was the upgrading of the facilities. The plan is to have Emergency Obstetric Care (EmOC) at the PHCs and make a selection through what is called First Referral Units (FRU), where some of the units have a gynecologist available and the possibility of anesthesia and Caesarean operation around the clock. Then complications will be referred to these facilities. This will also require an improved transport system. (HO1-3) It was mentioned that a future plan is to make selections for this, to send the complicated cases to the district hospital and keep the normal deliveries at the PHCs. (HO2)

The time for staying in the facilities after delivery was a subject of different opinions. The informants working with administration only referred to the guidelines where women are encouraged to stay for 48 hours, due to possible complications. (HO1-3) The chief doctor, on the other hand, did not find this necessary. If there were any complications he would like the women to stay longer, but if everything was normal, he saw no need to stay.

Introduction of the new workers: ASHA and Yashoda

The ASHA was considered an important worker. She was referred to as the main person to inform the women about the program, and the main person to make them come to the clinic. (HO3,5) She is paid with incentives to ensure that the work is being done. (HO3)

To improve the service in the facilities, NIPi has introduced a new health worker known as Yashoda. The informants from NIPi believed the Yashoda made a difference for the mothers' experiences by giving them support, care and information through their stay. Her task is also to keep silence and peace around mother and child, and make sure visiting hours are respected. The importance of both the ASHA and the Yashoda being good communicators was emphasized by the NIPi representatives. (HO1,2)

Consequences and benefits

An important benefit from the JSY was the aspect of equality, according to several of the informants. (HO1-4) Offering all women the same services will possibly result in a social equalization. (HO1) Also the question of empowerment of women was presented as a possible consequence of the program. It was stated that by inviting the woman to stay in the facility, and at the same time practice a strict regime for visiting-hours, you can empower the mother by giving her information and skills to take care of her baby, and with this also improve her status in the family. The empowerment and equity perspective was raised by several of the informants, and it was clearly stated that help in deliveries was considered a right for the mothers: "Empowerment has several dimensions. Here we talk about basic rights." (HO3)

6.2.2 Positive indicators

All the informants reported that according to statistics, MMR is decreasing. The Chief Doctor at the PHC referred to dramatic improvements in local numbers. He indicated that before JSY, the PHC had 20-30 women deliver every month, and now the number was around 150: "Yes, this is a big change (...) Now only 5-10 % is home deliveries out in the villages (...) It's a success". (HO5)

It was claimed that a very good beginning has been achieved, and that next is to continue the good work by improving facilities and service. One of the NIPi representatives emphasized that the implementation of the JSY was a good sign by itself. He also focused on how to utilize the money and the possibilities: "It has been bad before, but it has been bad without money. Now, it is bad with money. And then, over time, you will get a certain improvement." (HO1)

The idea that JSY is an effective strategy to raise visibility of the problem was presented by several of the informants. One said: "If no one comes and the door is closed, then the child will be born and die at home. Now, they will at least die in the hospital, so we can increase the focus on it." (HO1)

The fact that women are now actually coming shows that NRHM and JSY differs from the many other programs that have been implemented for improving health in India through the years. This was emphasized by all the informants as a key for further work and planning.

6.2.3 Challenges

The informants identified different challenges for both the JSY and the NRHM, due to medical, social, cultural and political factors. Even though claiming that reports and numbers already show that the programs have had a positive impact, they are criticized as improvised solutions. Just like earlier strategies for improving health in rural India, the NRHM can be called an “emergency solution”. (HO1)

Diversity and politics

For Uttar Pradesh, the cultural and political aspects were considered special challenges. Firstly, the state’s size and diversity make it problematic to reach all the people using the same methods. Secondly, the government in UP is unstable and difficult. (HO1,3) It also has very limited collaboration with external agencies or international aid organizations, in spite of being one of the poorer states in India and despite foreign agencies’ numerous attempts to get involved in organization. If local implementation fails, the best plans and intentions from the state cannot succeed. (HO1,3) It was also stated that as long as the real problem, in this case the politics, is not addressed, the obstacles will remain. (HO1)

Lack of resources

Another major challenge presented was the lack of resources. Both equipment and medicines were mentioned, as was the lack of personnel; this latter was a big concern of several of the informants. Especially if the women are staying for 48 hours, as recommended, there is neither place for the women nor someone to take care of them. Another concern was that midwives at the PHC are mainly ANMs, and the education and experience of this group varies widely. (HO1) Their responsibility in the facility is limited, and it was presented as a problem that an ANM does not have the authority to refer a mother or a child to another hospital if needed; she must wait till the doctor comes. Often this means waiting till the next day. It was also stated that most of the doctors working in the governmental institutions maintain a private practice to supplement the low income from the government. This makes them less available at the PHC.

The ASHA was highly valued by the informants, but there were also challenges related to her work. Her tasks were considered to involve a huge responsibility for a woman with such

limited education, and they referred to areas where the ASHAs had been handing out antibiotics and other medicines in the villages by her own order.

Problems on referrals

The infrastructure was a problem addressed by the health officials: For improving a referral system, they pointed to the need for roads and vehicles. The Chief Doctor at the PHC said they had no transport available for referrals of patients. They could help with money for transport if needed, but they had no vehicles.

Incentives and expenses

Corruption, or kick-backs, as the informants termed it, was considered a problem by some of the health officials. Some reported that the hospital staff charged the patients, while others claimed that this did not happen. The administrators in Delhi were clear in their messages that such payments were a well-known problem:

Yes, whether you call it corruption or tradition... I don't know. But it is normal to give a present or compensation to those helping you with delivery; it is so common that it will be demanded from you if you don't give anything. (HO1)

He also told stories from the field where he had found the practice of paying more if you had been so-called lucky to get a boy. Most of the informants acknowledged that payment under the table was a problem in the facilities. They also said that reports and evaluations on JSY showed that in many places the out-of-pocket expenditure would exceed the incentives. (HO1,2) The informant who was working at a PHC denied any knowledge of charges in the clinic; he claimed that everything was free for the women. For the cost of medicines it was the same. According to the informants who did not work close related to the clinic, the women were charged for medicines. As one informant explained:

I have seen places myself where the family is sent out to buy medicines from the pharmacy, while the institution has a lot of medicines in stock, but they are sent out to buy it because of a kick-back agreement between the doctor and the pharmacist. (HO1)

Of the informants who did acknowledge this as a problem, none had any clear suggestions for improvement. One of them said: "Corruption is a problem in this country. It is difficult to prove and difficult to measure." (HO3). But in the beginning of the JSY, he explained, the women had been given the incentives in cash, and this had to be changed to check-payment because it was too difficult to keep control with what they actually got. With giving the check they could at least ensure she got the money in her own name, he said.

The chief doctor at the PHC also raised the desire for extended incentives. He stated that 1400 rupees is not much in India today, and that with a higher sum, the women would benefit more, and so the program would be even more successful. (HO5)

Quality of care

Questions around the medical treatment in the facilities presented concerns of varying degrees. The informants were asked about the potential risk of “over-medicalization” when births move into the institution, and they viewed this differently. One informant said this was a growing concern, but that the debate around this was a good sign in itself: “Questions around quality like this tells that we have now come up on another level.” (HO3) He explained what he saw as a “give-and-take situation”, where the over-use of medication must be seen in a broader picture:

First, with a MMR at 254, we must first concentrate on giving women a safe and clean delivery, and the first step is to bring them to an institution. (HO3)

When the informants were asked about use of medication in the facilities, they were also given the example of the informant group in UP, where all the women with normal deliveries had got injections of Oxytocin, many of them also without knowing what they got or why. The main reasons given for this were that it was due to either lack of facilities (pressure from new women coming in) or due to a desire to get it done quickly, from mother or midwife or both. One informant also suggested that the women probably did not know what they got, and that they were mistaking the tetanus injection for being given under delivery. (HO2)

6.3 Perspectives from the Asia Pacific Midwife Conference

The learning and principal messages from the Asia Pacific Midwife Conference (APMC) consisted of different perspectives on midwifery and reproductive health. The conference was arranged by the Indian midwife association, Society of Midwives, India (SOMI). This organization was registered in 2001 and aims to bring midwifery on the agenda for improving maternal and child health. (23) A broad range of representatives from other occupational groups, such as doctors, politicians and human rights activists, attended the arrangement and contributed to a comprehensive congress presenting different views. Other stakeholders, the press and representatives from various donors were also present. The organizers used Millennium Development Goal 5 as a reference for objectives and visions. For this study, data was gathered in three core themes:

- Targets and visions
- Subject development and academic progress
- Collaboration and funding

6.3.1 Targets and visions

Objectives for reaching the MDGs

For reducing the maternal mortality according to the MDG5, the organizers' three main objectives were formulated in the conference program:

- Family planning, safe abortions and reproductive counseling
- Skilled birth attendants for every delivery (SBA)
- Emergency Obstetric Care (EmOC)



Organizers at the AMPC

Questions around the three objectives were addressed from different angles. Proposals to strengthen midwifery, improve the educational system and focus on the professional academic development were presented as main ways of approaching the subjects.

Strengthening midwifery

Development for the profession and identity for midwives was addressed in three main areas: Education, regulation and association. These three were seen as pillars in the attempt of bringing midwifery to the forefront of maternal and newborn care.

The way from home births to institutional deliveries has involved changes among the professional groups. Statistics show that in the cities, most women are now delivered by a doctor, and thus it is a challenge to keep the normal delivery a profession and a responsibility of the midwife. Develop skills through education and training programs, and focusing on being updated with evidence- and research-based medicine, were considered essential for the midwives to give the best care for mothers and to develop and maintain midwifery as a profession.

A sub-heading frequently used in the conference, both on material and presentations, was “Empowering women, enabling midwives.” The importance around the empowerment of women and identity of midwives were topics addressed from different angles.



Midwives practicing skills at the conference

Improving education of skilled birth attendants

Education for midwives in India gave rise to concern for different reasons. With midwifery now being an integrated part of education for general nursing, there are a lot of “qualified” midwives who have never worked with child delivery. This can have a destructive effect on both skills and identity for midwives, the latter especially when it comes to working with other groups of professionals. Another concern was that in many places the work force was merely ANMs, with only 18 months of education and poor supervision. The ANMs were considered skilled birth attendants, but in need of supervision and extended practice.

Attention was drawn to what was identified as a huge gap between theory and practice. Lectures taught and skills learned at the university are very different from what is seen in the clinic, especially in the rural areas. SOMI emphasized that they want to work for a better strategy for education and for regulation of the work force, especially through more practice and training of the midwives working with deliveries. The desire for an education division for nurses and midwives was also on the agenda.

6.3.2 Subject development and academic progress

From the four days' extensive program, the following topics were found specially relevant for the women giving birth in Mursan: The question around quality of care, assessment of satisfaction, the use of Oxytocin, possible consequences of institutional deliveries and the bridge to TBAs.

Quality of care

Quality of care is an essential topic in the change towards institutional deliveries, when the women are encouraged to come to the institution. To question treatment and services, and how these can be improved, is of great importance when it comes to creating a sustainable intervention. First this regards medical treatment, to get the best outcome to reduce maternal mortality. In addition to this also the psycho-social aspect is essential for making the stay in the institution a good experience for the mothers. This will be decisive for their relation to the health care system, which again will influence on medical outcomes in a longer term. This was thoroughly addressed by Kilaru (38) in a presentation about women's experiences of quality of care during delivery. The presentation was based on data gathered in rural Karnataka from 2007 to 2009, soon to be presented in an article. It was concluded that an aim of 100% institutional deliveries left no choices for the women, which could result in poor quality of care discouraging future contact with the institutions.

Assessment of satisfaction

Related to quality of care was the assessment of satisfaction. To ask the users how they experience things was considered crucial to be able to make improvements. Assessment of satisfaction was presented as a challenge, because several studies had shown it difficult to make these women talk about their experiences. (45) Nevertheless it was considered important to try to give the best services possible.

The use of Oxytocin

Another point with great relevance for the women in Mursan was the extensive use of Oxytocin. Karachiwala, Matthews and Kilaru (46) gave a presentation titled "The use and misuse of Oxytocin", showing that misuse and abuse of the medication was widespread. Oxytocin is a medicament stimulating uterus contractions, in many settings used as routine after delivery for prevention or treatment of post partum bleeding. Guidelines and recommendations from WHO and NRHM say Oxytocin can also be administrated during delivery, but on indication, with monitoring and according to special procedures. Research

from the institutions showed that it is frequently given without indication and without monitoring, to “increase labour”. The cost of it was also reported to be high, even though the medicament is subsidized and supposed to be free for the women. (46)

A bridge to the TBAs

The work of TBAs was addressed and acknowledged in many sessions. The possibility of losing something important of the culture was pointed out, when leaving a long practice behind without being aware. Thus it was suggested to keep the best from the two traditions. The change away from TBAs to modern birth medicine was also linked back to the time of colonization, where the western ideas were forced upon the Indians. Home births were addressed as something positive, and as something the midwives wanted to keep, but with the assistance of a skilled birth attendant.

6.3.3 Collaboration and funding

The importance of broad collaboration with other key groups was emphasized through the whole program. The doctors were mentioned as important partners, and the International Federation of Gynecology and Obstetrics (FIGO) had an active representation at the arrangement. Also funding agents and international policy makers, such as UNICEF, UNFPA, NIPI and Sida, were present both among participants/speakers and sponsors. The call for action came from a broad group of professionals. The fact that all these different professionals, stakeholders and sponsors were meeting at a conference arranged by the local midwife association was alone a sign that the situation for women and midwives is improving; this attendance could be considered an acknowledgement in itself. Hence, this conference was important for increasing awareness around both midwifery and maternal and reproductive health. Also participants, speakers and funding agents from other countries, from all parts of the world, spoke about an increasing interest and awareness of Indian maternal health in the international society.

“Life and death is a political decision”

The heading above was a title used in a session about setting standards for safe child birth. Political aspects were thoroughly addressed, and the Minister of Health of the state of Andhra Pradesh and other prominent persons were chief guests at the conference.

NRHM was on the agenda several times. Even in the inaugural speech it was stated that this program is “making a difference”. Identified challenges for the midwives in the NRHM were problems with mobilization and the lack of personnel in the PHCs. Key words for the births

should be “safe, skilled and sensitive”, and there should be an efficient referral system with facilities and blood available around the clock, corresponding to the criteria for EmOC. They also saw a challenge in making the women utilize the services, and a plan for this was to “Encourage motivation and awareness about government services”. For this also the work of the ASHA was considered a key factor.

7.0 Discussion of findings

The movement from home births to incentive-based institutional deliveries involves several changes and possible consequences for the women giving birth, for the midwives helping them and for the policy makers working with the programs. This study has six major findings. First, the utilization of the services was limited and seemed to be highly dependent on the work of the ASHA. Second, the women expressed an overall satisfaction with the institution, in spite of the facilities maintained poor standards regarding equipment, treatment and personnel. Third, the study identified a change toward viewing child birth as a medical event rather than a natural happening. Fourth, the women were charged in the facilities even though the services were supposed to be free. Fifth, the changes may have an influence on the family structure and can sixth, also possibly contribute to empowerment of women.

7.1 Utilization of the services and the role of the ASHA

All the women interviewed had recently delivered in the local governmental facility and received incentives, according to the inclusion criteria for the study. Except the delivery itself, the utilization of the NRHM's services was limited, both regarding ante natal and post-partum care. The need for a compound health care system as a factor to improve maternal health is suggested by both international standards and local research. (6;24;47) This includes focus on the different aspects of pregnancy and child birth: ante natal care (ANC), delivery and post natal care (PNC).

Pregnancy and ante natal care

Many of the informants had been to one ante natal check up during pregnancy. These mothers reported that the ASHA had taken them to this one check-up, and that the purpose was to get the tetanus-vaccination. Numbers from an assessment of the JSY scheme in Uttar Pradesh from 2008 (10) show high numbers of utilization of ANC, with 95 % of the women registered during pregnancy and 82.4% receiving at least three ante natal check-ups. Research done in another district of U.P., the Varanasi District, show low utilization; here only 13% of the respondents had attended all the recommended elements of the program. (36) These numbers, compared with the findings from the Hathras District, indicate that there are big differences within the state.

As with child delivery, the ASHA also gets incentives for bringing the women to the health center for vaccination. The women themselves do not get any incentive for this (except from

the health benefits from being vaccinated), but with the ASHA as the initiative-taker, many of the women got vaccines during pregnancy. In an area like this, where home births have been the normal standard, there has been no tradition for ANC during a normal and healthy pregnancy. Because many of the women now had attended at least this one check-up, it may be that with the work of ASHA the situation tends to change in this regard. Still it is unknown whether they would go even if the ASHA did not take them. It is also unknown whether the ASHA would inform them and tell them to go if she did not get any monetary reward for it. Officials from the Ministry of Health and Family Welfare expressed that payment for performance was the intended method to get things done. If you pay a fixed salary, it was said, the workforce would not be as functional as it is with incentives. This view can be supported by the information from Hathras.

The recommendations for ANC under the NRHM contain at least three check-ups during pregnancy, including two doses of tetanus and distribution of IFA tablets. (10) Most of the women interviewed for this study went to only one check up, which corresponded to a visit for which the ASHA got incentives.

It must also be questioned whether the women have a place to go for the ANC. If the local health center encourages them to come only this one time, it will not help if the ASHA or the mother herself sees the need for going several times.

Delivery

Statistics from the National Family Health Survey (NFHS-3) show that only 18 % of the women in rural parts of U.P. delivered in institutions in 2005-2006. (13) This has increased rapidly, and in 2008 47.5% of the women had institutional deliveries. (10) From the Chief Doctor at the Primary Health Center (PHC) it was said that now 80% of the women in the area deliver in an institution. He had seen a huge change since he was employed there, one and a half year ago, and he was very content with the current situation.

Through the interviews with health officials in Delhi, it was presented that JSY also included a part for encouraging safe home delivery, where a mother should receive 500 rupees (69 NOK) for having a skilled birth attendant to help her at home. This was never mentioned in the Hathras District, neither in informal conversations in the community nor among the informants. Among the women who had previously delivered at home, none of them had an SBA to assist, and no one mentioned this as a possibility. Most of them had been assisted by a dai, but when asked more in detail about what the dai did, they explained that she was

normally not there for the birth: the dai was called for after the baby was born to cut the cord, deliver the placenta and give the baby a bath.

The Chief Doctor at the PHC, though, said home delivery with assistance from a skilled birth attendant was still encouraged, but that the overall goal should be to raise awareness of institutional deliveries.

Post-natal care

Under the guidelines for the JSY scheme, women are encouraged to stay 48 hours in the facility after delivery. (7) Initially this was a demand, and a premise for receiving the incentive-payment, but, according to the representatives interviewed at the Ministry of Health and Family Welfare, this was subject to so much cheating that it was changed to a recommendation instead. The medical reason for having a woman for observation after delivery is solid, with post-partum bleeding being one of the major causes of maternal deaths. (4) For the women delivering in the PHC in Mursan, staying in the institution did not seem to be an option. Only the woman who experienced post-partum complications stayed in the facility for 48 hours; the rest were discharged quickly after delivery.

The Chief Doctor said there was no need for the women to stay in the institution if they were healthy. With the limited space in the facilities, there was also no room for the women to stay even if they had wanted it.

A “continuum of care”?

The findings from Hathras agree with research done in other rural settings in India, with poor services for ANC post-partum care. (2;5) Lahariya (24) refers to the need for “a continuum of care”, to the need for an extensive health care service that can ensure safe conditions through the different stages of pregnancy and child birth. Matthews, Ramakrishna, Mahendra, Kilaru and Ganapathy (5) point out that it is not possible to get all women to deliver in an institution, so the ANC should be improved to identify risk pregnancies. In international birth medicine there is also an increasing awareness around the importance of selection and differentiation between normal- and risk pregnancies. The assessment of risk continues all the way through pregnancy and delivery and aims to ensure that the woman gets the medical help and care she needs. Maternal mortality is not depending on the birth alone, and especially if full coverage of institutional deliveries is not considered feasible, other factors must be taken into consideration. (2;5)

In Mursan, the main focus seemed to be the delivery, plus one check up where a dose of tetanus-injection was given. Like findings from research done in similar settings, (2;5) the women shared experiences of discharge quickly after delivery and poor or no follow up.

Deciding factors in a new time

Different factors for the women going to the facility for child birth were identified. Data from similar and more comprehensive studies presents many factors for why women go to institutions for delivery, and it also presents factors for why they prefer to stay at home. (2;5) These studies were done before the implementation of the JSY and present factors identified before the incentives could be taken into consideration. So, while the women in Mursan, after the JSY, said they went to the institution for the facilities, medical safety and lack of support at home, numbers from a similar setting from 2005 (5) show that 89 per cent of the women planned home births for the opposite reasons: they wanted support from family, they were following local traditions and viewed birth as a normal phenomenon. And while the women in this earlier study had what was defined by the authors as “a poor understanding of urgency”, many of the women in Mursan said they went for safety, saying that it was better to be in the institution if something occurred during the delivery.

The opinions around the lack of help in the homes, and the idea that dais nowadays do not have sufficient knowledge, were noteworthy, considering the fact that there has been an extensive training of TBAs in this area through the years, with re-training still taking place. Other statements indicated that something was considered new now, with the women saying that no one delivered at home these days and that the women’s bodies were not strong like they used to be. This suggests that a change is happening on several levels at the same time; changes in the society and changes in medicine are interlaced, thus making it difficult to isolate particular motivations from the bigger setting.

The incentives were not mentioned as a determining factor for going to the facility by any of the women. When asked about the money they said it was a good arrangement, but many of them stated clearly that even if it was good, it was not a reason for going. These answers can have been due to several reasons, among them pride, insecurity or distrust in the foreign visitors. Still many of the women and their families said through the conversations that they were poor people, and they seemed to be open about their socio-economic situation. So, considering their responses as a result of their perception of reality, they gave different reasons other than financial for going to the facility. Then, if the women’s reasons for going

are seen together with the utilization, questions around motivation seems to again lead to the ASHA, and to the fact that the women decided to use the services the ASHA got incentives for. This might of course be because the incentives for the ASHA are wisely placed, on which also most naturally would be utilized, but seen from the other side it might indicate that the influence of the ASHA is more decisive than expected.

The role of the ASHA and the role of incentives

Current literature suggests that the JSY has become too dependent on the work of ASHA, and that her tasks are too many and too extensive. (24) This view can be supported by the findings from Mursan, in the sense that the incentives for the ASHA seemed to be an important factor in driving utilization of the facilities. It is a clear danger in a situation like this that only the incentive-based parts get utilized: what is linked to the payment is considered important by the users, and the rest will not be emphasized or even mentioned. This might, as we see from the increase in numbers of institutional deliveries, provide short-term benefits. Still, if health information and awareness are among the overall goals, the method of incentives can be questioned and criticized when asking to which extent these goals are met.

The incentives are a key factor and a driving force in the program, and their importance should thus be approached from different angles. Based on the findings from this study it is relevant to turn the question around and ask if the incentives, even though they clearly show an increase in the use of payment-linked services, contribute to the creation of a new problem? When introducing such payments into health policy, it is a clear possibility that people only become aware of- and use the incentive-linked elements. Then other parts of the program, which are still highly recommended and important, might just be abandoned or left out. An example of this would be if the ASHA reports having informed the women about the importance of going to three check-ups, as recommended, and the mothers respond by only attending appointments for which ASHA gets incentives. To find a balance in this seems to be a challenge; how to get the benefits from the incentive program and still trying to avoid the problems it might create?

For the ASHA it will also be question of priority. Considering that informing pregnant women and following them to delivery are only some of her many tasks, she will have a busy job with giving service to the population of the villages with her skills and resources at hand.

Decisions in context

Decisions around going to the institution or not must also be seen in a realistic picture. The women, the mother, her older relatives and also the ASHA, all navigate between the known and available options. And as one of the mothers in Mursan said, “Whatever is written in your destiny, you have to go there...” This statement can say something about how these women view the question of decision making. Their stories, and the information about the community they lived in, all indicated that they were not used to thinking about what they wanted.

Another perspective on this, presented on the midwife conference, was that if the government aims at full coverage of institutional deliveries with JSY, it can appear that it is not leaving much choice for the women. (38) It was stated that with not giving the women a choice, a possible outcome could be that many women received poor services that discouraged them from future contacts with the institutions.

Determination factors for utilization should be important considerations when the programs are extended or further developed. Since the NRHM is a project for such a big area, it is bound to be very general in the guidelines. Still, with the implementation being a responsibility of the particular states, local adjustments are possible. It can be essential to understand the local context when working with health interventions, and reasons for decisions may be a key for the policy makers. (34) To make changes sustainable it is necessary to understand people’s decisions on a deeper level. Then first it can be possible to understand what will happen when the premises change, for instance if the incentives are taken away or if the role of the ASHA is re-structured.

Intended and unintended consequences

The programs and the utilization of them will have consequences. Some of those consequences will be intended and might turn out the desired way. Others will be unintended; the unintended consequences can also be positive or negative and their impact must be taken into consideration. In a planning phase of a project, or when doing measurements during implementation, possible consequences should be investigated and considered. Based on the findings from this study, possible outcomes of the changes in Hathras will be discussed through the following chapters.

7.2 Unspecified satisfaction

One major finding was the women's general satisfaction with the facilities and the service they were offered. The National Rural Health Mission is an attempt to give proper and equal health care in spite of the huge differences in India's vast population. The aim is to improve health care in the rural areas with a common policy for the states, but the experiences in the different areas and at the different facilities will be dependent on several local factors. For the informants in the Hathras District, the statistics show that they live in some of the poorer conditions of India's rural parts, (7) and the local facility, the PHC where the women had given birth, was then probably of poor standard compared to many other places.

The requirements for what should be defined as an "institutional delivery" can be a subject for discussion. The requirements for EmOC are quite clear, including the necessary professionals and equipment for treating complications during pregnancy and child birth. (21) Still today there are many cites in rural India where poorly equipped PHCs and sub-centers are functioning as "institutions" in this regard. In some of these places, the women might not get much more help than they would get delivering at home, with the exceptions of the presence of a skilled birth attendant, in most cases an ANM. When seeing situations in isolation, a critical approach requires asking whether it would be better just to stay at home in familiar surroundings, without the effort and cost of transporting the woman when in labor pain. Viewed from another angle, and in the light of development goals, where this is one of many steps toward a better solution, it can look different. As stated clearly by some of the health officials, the first step is to increase the number, and then the next thing will be to push for quality. What is important, anyhow, both for the health of the single woman delivering now and for maternal health developing in a larger picture, is to explore what is happening along the way in the programs and to be aware on how this influences the further process.

To deliver in the facility: The distance between theory and praxis

Most of the women interviewed said they had a good experience with giving birth in the PHC. They said the facilities were good and the nurses did a good job, and even though none of them said the incentives were the reason for going there, most of them expressed a clear satisfaction with the incentive program. Also many of the women who had originally planned to deliver at home, and went to the institution because of lack of progress in the delivery or unexpected occurrences, expressed satisfaction with the help they got. Nevertheless, some of the women were unhappy with the help they got in the facility. The negative experiences were

based on meeting with personnel who were poorly skilled, uncommitted or behaved in a bad manner.

Corresponding with statistics on availability of workforce and equipment in the governmental facilities in U.P, (15) the findings from this study present a situation of a much weaker standard than the desired “gold standard” in obstetrics. Compared with the desired standard, the described facility had poor or missing equipment, too many patients per nurse, a doctor available only until 2 pm, bad hygiene and inadequate medical treatment. Still it was, both based on women’s and health officials’ stories, and also on the researchers own experiences from the villages, in many ways better than the facilities the women would have at home. And as stated by the health officials, in the institution they are seen and acknowledged; if their birth contributes to the register of maternal mortality they will at least try to be saved and their death will be registered. To see the situations in the institutions in this context, as a step toward a better system, can be a way to facilitate further work and development. It is also a way to explain and justify that women are encouraged to come to the institutions for delivery when the quality of the treatment can be debated. This view was supported by the health officials, who literally said that the first step in the program was to increase the number, and then afterwards look at the quality. The NRHM aims to reach a huge number of people, and it is not possible to make a total change from one day to the next. The development must go brick by brick, even though this means that the gap between intentions and reality is still obviously striking.

Quality of care

Most of the women had received little practical help, except from medicines to speed up the contractions and then assistance for the delivery, but they expressed happiness about both the facilities and the work of the staff. Then, between the satisfied women and what can be defined as insufficient help, the question of quality of care arises.

Questions on quality can be approached from different angles. What defines quality? And who is to define what good quality is? And then, if we have different opinions about the quality, who is to decide what is right or wrong? Quality also holds several aspects. When talking about measurement of maternal mortality, we talk about quality of treatment and medical procedures. In addition to this, psychological and emotional support is considered essential for good quality in maternal care. (35)

Regarding quality of treatment and procedures, the international standards in birth medicine are quite clear. Still the guidelines are subject to frequent changes, due to research- and evidence-based development. What was considered good medicine a decade ago is now proven to be wrong, and the knowledge continuously develops toward a better understanding. This suggests an importance of being humble and careful when approaching other cultures with different practices, knowing that our own understanding of what is correct is based on what is considered right at this very moment. But at the same time this must be balanced, both ethically and practically, with the work of improving conditions we believe contribute to a persistent high MMR.

It was quite a distance from the delivery room at the PHC in Mursan to the offices in Delhi. The Chief Doctor in Hathras, on his side, seemed to have his ideas somewhere in between the policies from Delhi and the experiences of the women. From the midwife conference, it was stated that there are huge differences between the maternal care in the rural and the urban areas. This corresponds with most of the issues in the Indian demography, with factors such as poverty and illiteracy being more widespread in the rural parts. This is also some of the background for the National Rural Health Mission. (7) It was discussed at the conference that there is a huge gap between theory and practice, and that the medicine spoken of in the offices does not reach the women who are delivering. Still, the women view their situation from their own perspective. They will probably relate and compare their experiences to what they know from before, and as long as the facilities are in accordance with the standard they know, they are likely to find it satisfying. Another perspective is what some of the mothers pointed to, that when they were in trouble, whatever helped seemed good, and that nothing seemed to matter as long as they got the baby. And if you have no references for a desired standard, you might be happy with what you get. The women seemed to appreciate the fact that they now could go to a hospital to deliver (and even get money for it), and this alone would be enough for appreciation and satisfaction to some extent. The women also expressed that they considered themselves living in a “new time”, and that they were a part of a development. For the women in Mursan this development and change seemed to add something, rather than take something away. They got a new service introduced, and more help and attention, and this itself seemed to add some value.

The psycho-social and emotional part of the care in the institutions was mainly given by the female family members. With the family following to the facility and being present in the room, it allowed them to take care of their relative all the time. At the midwife conference one

of the biggest challenges presented for the quality of psycho-social support was the shortage of health personnel. The psycho-social support was emphasized and acknowledged as essential, but with today's situation the number of women per midwife in the institutions does not allow sufficient attention to the individual woman delivering. Most of the mothers interviewed reported that the family was the main support for them at the hospital, which accords with the tradition of the female family being important in the happening of child birth. This situation forms what can be seen as a sliding transition from delivery being a concern of the family to a responsibility of the health care system.

Women's experiences and assessment of satisfaction

Measurements of satisfaction can say something about what is stirring under the surface of the activity and how a change will develop further. Many of the women in the Hathras District said they were satisfied with the help they got in the facility, but when asked about what was good, and what made them satisfied, few could specify what they meant. This might have been due to a number of reasons. As touched upon earlier, these women were not used to expressing what they want. They were also not used to being interviewed or to talking with strangers, and these factors alone could have resulted in difficulties with expression of details. The presence of the mother-in-law and other family members can also have made them shy and taciturn. At the same time, the difficulty with assessing the satisfaction of women giving birth in institutions was also acknowledged as a challenge at the midwife conference. Still, mothers' perception of the quality of the services was defined as an important indicator of health care, (45) and it was clearly stated that effort should be made to better the psychological environment to improve the mothers experiences. With the psychological environment decisive for the experiences it will be crucial for later decision making and for the programs' sustainability. Experiences are also frequently communicated, and the informal "grapevine" is powerful in an area where only a limited part of the population has access to news or an ability to gather information. Thus, perceptions of quality will be a determining factor for new choices, which again will impact the development of the health care system, maternal mortality and not least the experience of being a woman in rural India.

Relation to the health care system

For many of the mothers, the institutional birth will represent a first meeting with the health care system. From the health officials it was stated that the incentive program could open up a door for the women, a door which would then be open for other types of consultations when needed at a later stage. Traditionally, poor people in the rural areas would not go to see a

doctor before they were seriously ill, and the hospital is associated with very sick people. For many it would also be a question of caste. Even though the caste system is technically abolished in India, it is still alive in many regards, especially in the rural parts. For women from lower castes it would earlier not be an option to go to an institution to deliver their children. Now, with the incentives, they are invited to come in a new way, all on an equal level. When being born in the institution, the baby will also be enrolled in vaccination programs, and so the family will go there again for new vaccinations for the baby. This gives reason to believe that the families will go back later, if they need help for the child or themselves, and they will get to know about the other services available at the PHC.

7.3 Changing view on child delivery: from natural to medical happening

Pregnancy and childbirth can be seen both as a natural process and as a medical event. In rural India it has traditionally been viewed as a natural process related to family and culture, and most of the care has been given in the homes. There is little doubt that the increasing number of hospital deliveries is partially a result of the JSY, but according to the informants in Hathras, there is also reason to believe that change has happened in different areas and on several levels at the same time.

Abandoning traditional rituals and TBAs

In the district of Hathras more than 10.000 TBAs have received training over the last decades. Still the women who had experienced home delivery reported that the dais normally came only for the work that was left after the baby was born. Literature on TBAs from other settings (19;20) shows that this can differ from place to place, and that in other places the dais will be the ones to assist also for the delivery.

India is known for having a religious influence in the everyday life. The Hindu idea of destiny and reincarnation, and the belief and trust in a greater purpose, can add meaning to a life in difficult conditions. There are many old rituals and traditions for pregnancy and childbirth in rural India: what to do and what to eat and, not least, what to avoid. Many of the TBAs have been trained in a western tradition, but they are still a part of the local culture and will in many regards bring the old rituals into the work. TBAs are a big group of women with varying skills, and it is difficult to talk about them in general terms. (19)

The midwives at the conference were concerned about the TBAs' missing role in modern birth medicine. A strong desire was expressed to keep the best from both the traditional and

modern medicine, and use them together. They stated that in leaving the old traditions behind, without reflecting on what is still serving a purpose and what can be combined with modern medicine, we are in great danger of losing both an important cultural aspect and what can be an important supplement to modern treatment. The health officials did not share this view. None of them saw a role for TBAs and old traditions in the move toward institutional deliveries. On the contrary, the old traditions were explained as one of the barriers for people to understand the need for and uses of modern medicine.

Back in Hathras it was reported that the dais now often refuse to come for assistance. This was not explained further, but it can possibly be interpreted that the local dais are withdrawing as a response to the increasing desire for institutional deliveries. Lack of assistance in the homes was presented as a reason for going to the hospital, but it is hard to conclude from the material whether this represented a loss for the women, or if it was expressed as an explanation for a positive change.

Home birth versus institutional deliveries

The women in Mursan had various opinions about the distinction between home and hospital deliveries. Some of the women talked about development, good facilities and good help in the institutions, while others said they saw no difference between giving birth in the different places and that unless you had medical complications, it was the same thing happening home and in the hospital.

With presenting hospital delivery as an important and available factor for medical safety, the idea should be that the women become aware of a new need. Some of them still did not see the need after delivery, and they said they would deliver home for a next birth if no problems occurred. Others again referred to happenings with tragic outcomes, with relatives or neighbors dying, which had made them aware of the necessity for medical safety.

Over-use of Oxytocin

All the women interviewed had normal, uncomplicated deliveries at the PHC. Nevertheless, most of them got medication, in the form of injections or intravenous infusion, to speed up the labour. Some of them knew it was to increase the contractions, to have a quicker delivery, but many of them did not know why they got the medicine.

The medicament Oxytocin is an artificial human hormone which, among other things, makes contractions for labour. It is also used after delivery to treat or prevent post partum bleeding,

one of the major causes of maternal death. The mechanism is uterus contraction. According to international birth guidelines, Oxytocin shall be given only on medical indication, meaning if medically appropriate or necessary. It shall be administrated under supervision and monitoring, and after a clear procedure. (48) Misuse of Oxytocin is proven to have several undesirable and dangerous consequences. (46) When a medication like this is given in a normal birth, the birth is no longer natural. This means that the risk, the need for supervision and monitoring, increases dramatically. In this study site injections of Oxytocin seemed to be the standard procedure, irrespective of medical indication or need for supervision.

According to the women's stories, the medication made them deliver very fast and they seemed satisfied with getting it done quickly⁷. Also for the midwives at the clinic, with pressure from new women coming in and the limited space in the facility, it might be that quicker deliveries were desired. Research from a similar setting in another state showed that 90 % of the women delivering got injections during labour. (5) The use and misuse of Oxytocin was presented as a known and important concern at the midwives' conference, and the unnecessary interventions were presented as an important factor when investigating the quality of care. (46) The health officials had several views on this matter. A suggestion from Ministry of Health and Family Welfare was that the growing concern over use of Oxytocin was important but also a good sign, and that debate around quality of treatment like this was a step up to another level: if increasing the numbers was first step and pushing for better quality the next, then the second step has arrived. One of the NIPI representatives, though, suggested that the women did not understand what had happened, and that they misinterpreted the tetanus injection for increasing labor pains. Whether this misunderstanding occurs is difficult to know, but the statement reveals an attitude noteworthy of attention. If a general understanding from the authorities is that the women, whom they actually are making the plans for, are so poorly informed that it is not worth taking their interpretations into consideration, it can be a very dangerous sign. Many of the women in the rural parts of India are illiterate and have poor knowledge of medical conditions. Still, they are the ones intended to utilize the services and to benefit from them. If the information given is not received by them, it is by definition not sufficiently presented. Another noticeable aspect here is that it seemed to be a tradition for the local health workers not to communicate very much with the patients. From observation in the different clinics, I saw patients treated and medications

⁷ When analyzing these findings, I also inevitably draw lines to my former work as a midwife in Norway. I often wondered, when assisting women from other certain countries with delivery and they (or their relatives) asked for "injection for having the baby", what they meant. The answer is no longer unclear to me.

given based mainly on health workers' judgment, without conversation, assessment or further explanation.

Further implications of a change towards a medical focus

With moving the child births from the homes to the institutions, we also move the focus from birth as a natural happening to birth as a medical event. The women come to the institution and get medical help and safety. On the other hand, they might get unnecessary treatment and medical procedures that will overrule the natural process, and this has several implications. One, the woman is put under unnecessary risk, with the nurses interfering with her normal birth and actually creating a need for increased supervision that they cannot meet. Two, the women will believe that this is necessary and appropriate treatment. On a higher level this can have large implications and impact the maternal health services in the future. And if 100% coverage of institutional deliveries is an unattainable target, a selection of risk pregnancies, with focus on the ANC, would be another suggested approach. With focusing on the ANC, a target would be that the deliveries that need extended care get sufficient help, and those who do not need it will not occupy the space in the facilities. The JSY is based on the idea that institutional deliveries in general will lower the maternal mortality, but there is little evidence showing that this is true for normal deliveries. (37) This supports the idea of a different approach with higher focus on ANC and selection of risk pregnancies. Once the idea that medical safety can only be achieved in the hospital, it will be viewed by the public as a necessary service. For the NRHM and the JSY, this seems to be part of the purpose. Even though it was said that home birth with a skilled attendant was encouraged, and actually was a part of the JSY, the incentives in the local area were only known as linked to the institutions.

The dilemma of introducing modern medicine while at the same time maintaining child birth as a natural event was on the agenda at the midwife conference. With the institutional deliveries there is no doubt that what can be referred to as an "over-medicalization" is taking place. (46) This, together with the abandonment of the old traditions, contributes to the development of an understanding of birth as a medical happening that requires hospitalization and treatment. Another related issue presented at the conference was the implications for the sharing of responsibility between midwives and doctors. With the normal birth generally being a case for a midwife and the complicated birth being a case for the doctor, a change toward a medical view on childbirth will interfere with the tasks of the professionals and thus change the need for the different occupational groups. It was also said that in the cities there are doctors conducting the deliveries, while the rural areas still have nurses and ANMs to

assist the women giving birth. The increase of professional development and supervision in the clinics were two main factors mentioned to meet this challenge.

It is no question that development of medicine is necessary and important to reduce maternal mortality in India as in other places. What this material shows the importance of, though, is awareness along the way, and to steer carefully and control the process of introduction of new routines as far as it is possible. With just focusing on quantity and numbers for a long period in a program like the JSY, it is a danger that patterns and cultures are already established when you eventually start thinking of the quality. Then it will be much more difficult to make changes, because the routine is already there. Seen from another angle, with India's huge population, the strategy with first going for quantity may be the only way of reaching enough people at the same time. As stated by the health officials: it is a give and take situation, and the first step is to give all women a safe and clean delivery.

7.4. Financial matters: Incentives and expenses

Most of the women interviewed reported that they had been charged for services and medicines in the facilities. From what I could see in the interview setting, the women did not seem bothered when they talked about this; it seemed as if they spoke about something common, not something that was related to secrecy. Still, it was quite clear that many of them considered the payments unjust.

This situation was found to be well-known in the offices in Delhi. Both at the Ministry of Health and in the NIPI-office the informants confirmed that these payments were happening and that it was a problem. The Indian NIPI-representative was more reluctant to acknowledge this system; she said that sometimes it might happen but that it was not "encouraged". At the local level, from the Chief Doctor at one of the local PHCs, it was presented differently; he claimed everything was free for the women, both entrance, services and medicines. Also the one PHC nurse, who happened to be present at the interview with "Mother 16", was quick with instructing the mother to say she did not pay anything.

Corruption: different levels and different challenges

The contradictory information confirms that the transparency aimed for in the NRHM is a challenge. Implementation of comprehensive programs like the JSY is dependent on workers at many levels, and from the mentioned contrasts it seems that the different levels might have different understandings and different agendas. Everything is supposed to be free for the

women, but the problem with corruption seems to be pervasive. And the fact that the workers deny it, when they are asked, says something about them being aware of doing something wrong. Expenditure for institutional deliveries in other similar states was addressed in a report presented by NIPI in 2009, (49) showing an average (mean) cost of 2792 rupees for delivery in governmental institutions in the rural areas. In U.P. no such numbers were available when this work was done. And with the state government not wanting collaboration with foreign agents, the numbers are likely to remain unknown and unaddressed. The health officials in Delhi all stated that U.P. had a difficult situation and that the politicians ruled arbitrary. Among the mothers, on the other hand, it was said that they had faith in the state government, and they gave the state's Chief Minister, Kumari Mayawati, credit for the recent changes in the society, including the incentives for institutional deliveries.

Informally it was said, both in the community in the Hathras District and in Delhi, that charges were frequent also within the staff in the institutions. At all levels the workers could experience that they had to pay their seniors, either to get desired positions or simply just to keep the jobs they already had. Transferring and repositioning was widespread, and it represented a realistic threat that was commonly avoided with bribes.

Laharyia (24) emphasizes the need for extended incentives to enlarge the program in other directions, such as strengthen the ANC and providing PNC. Extended incentives were also mentioned by both women and the Chief Doctor in Hathras, though maybe with different things in mind. The women said it was "good" to get the money, but it was mentioned that 1400 rupees is not a large amount and that the government should give more. Some of the mothers having girl babies (and several girls from before) claimed the government should do more for those who have so many girls. Also the Chief Doctor believed that a higher incentive would make JSY more successful. Food items, services to the villages for pregnant women or services after delivery were mentioned as ways to spend the extended money.

It is shown from other low-income settings that the cost of need for extensive health care and EmOC can be devastating for the woman and her family. (33) Compared to this, it is clear that the incentives under JSY will decrease the barrier for seeking help for the Indian women. At the same time, the women in Hathras pointed out that still some women had to deliver at home because of poverty. They also pointed out the fact that if you need to pay for entrance and services on the spot, it does not necessarily help that you receive a check afterwards. The check-payment was introduced as a way to make sure the women got the money, to ensure it

did not all get out of her pocket while in the facility. The downside of this arrangement will be that the woman might not have the money to pay when she is there. She can then be denied access, like in the story of “Mother 8”, where her sister-in-law died at home because she could not pay at the hospital. This means that the women still have to save money for going to the institution, or to borrow from others. Then, if they do not see any other reason for going to the institution, the fact that the incentives disappear in expenses can result in the choice of staying home for delivery. Another challenge with the check payment is that some of the women did not seem to understand what to do to with it; how to turn it into money. This will hopefully change as the arrangement gets more known in the community.

The implications of changing prices and unofficial payments that occurred at all levels of the local society are difficult to predict. Some of the informants also gave information that was obviously incorrect, and the reasons for this could be many. What seems clear is that what in the western world is referred to as corruption is a big problem in the health care system in this part of U.P., a problem anyone involved will have to relate to. It also raises a question of the credibility of the governmental health care, if to strengthen the health care services also is to strengthen the grounds of this unverifiable financial system.

Maintenance of corruption

It was said from one of the health officials that in India it is a tradition to give a present to those who assist for delivery. It seems like this culture can justify or explain “transaction fees” for most things, and money is frequently changing hands. With this, the money that was meant to pay for extra food or support for the woman delivering in the institution, instead ends up as an increase of salary to the people working there. And then when the incentives are established as a part of the system, they can actually work as part of the maintenance of the corruption. Hence it can also create or maintain a financial barrier for later utilization, when the incentive program ends.

The Government of Norway supports Indian states with similar settings through NIPI. Regarding corruption and foreign support it is hard, if not impossible, to come from the outside and try to change the system. It is also debatable whether it would be right to come from another culture and try to change what is living in the local soul. Still, if the corruption is identified as a contributing factor for the maternal mortality remaining at a high level, it must be addressed. As for U.P., the fact that the state is reluctant to accept foreign assistance can

also be interpreted as a sign of secretiveness, that they do not want others to look into their affairs.

One informant said by herself that she didn't pay anything. This opens for a question about whether the staff has the possibility of considering each case individually, and decide themselves who they want to charge and how much. All the women recruited to the study had delivered at the governmental institution, which in this area indicated that they had a low socio-economic standard. It must also be mentioned that none of the informants were in need of extended obstetric help or referral to specialist hospital. How this would have worked regarding finances is unknown.

7.5. Change of the family structure

The findings from the interviews with the mothers clearly showed that the mother-in-law has a strong position in the family when it comes to reproductive health matters. This was also underlined by her natural and active presence in the interview-setting.

The female family members still accompanied the women to the hospital and stayed there for all the time the mother was admitted. The stories from the hospital indicate that in this society the mother-in-law is still very important in the situation, even though it takes place in a governmental institution.

If the facilities and the services develop in the intended direction under JSY, this will involve the women staying longer in the facilities. In addition to staying in safe conditions for maternity care, the mother can spend time with her new baby and learn about breastfeeding and nursing. Some of the health officials in Delhi saw this as a possible factor for improving the mother's status and influencing on the power structure in the family, that the mothers will be empowered by the knowledge from the hospital and take care of their own child in a different way from the start. It is hard to know how and to what extent this will influence the rural Indian family structure, and research is required to know more about this as a possible consequence. Changes in this direction also presuppose that the mother utilizes and appreciates the help she gets in the institution and that development is done in other fields: facilities must be improved to accommodate the women for a longer period, and the work force must be increased to meet the need for more health personnel. In addition to midwives and nurses, NIPi's introduction of the worker Yashoda is an attempt to meet the need for care

and assistance in the institutions: the Yashoda will inform and encourage the mothers and support them while staying in the facility. (26)

For the women in Mursan and the surrounding villages in the Hathras District, this is still a possible future scenario. Here the mother-in-laws were important for the health and well-being of their daughter-in-laws, and considering the poor conditions in the institution, the family played an essential part when a woman went to the institution to give child birth. Still the informants' experiences and opinions indicate that a change has started. With the "new" women going to the hospital, it can be interpreted as a division between the generations and indicate that something new is developing.

The fathers' role was now to help with practical arrangements. If the movement toward institutional deliveries shows to have an influence on the family structure, this might also influence the male involvement in child birth. Still, with the current limited facilities where the women share room with others for delivery, male participation on a larger scale will be difficult.

7.6. Empowerment of women

With maternal mortality and reproductive health as defined targets in the millennium declaration, the countries are obliged to put women's health on the agenda and make clear objectives for improvement. The NRHM and the JSY are both substantial initiatives for including women and children properly in the health care system. The programs aim for equality, and give the same benefits irrespective of culture, religion, socio-economic status or caste. The women from the poorest families, and those who still are associated with low castes or discriminated religions, will now get the same possibilities as other women. From the Ministry of Health it was said that "Empowerment has several dimensions. Here we talk about basic rights." With setting women's health and rights on the agenda, the NRHM and JSY are factors contributing to a basis for empowerment of women. These initiatives are also described as a beginning, and how ensuring these basic rights will affect the empowerment of women in a larger perspective is yet to be investigated. Statistics from U.P. show that there is a long way to go: the gender rate is skewed with 898 girls per 1000 boys, and more than half of the women in the rural parts are illiterate. (13)

Some of the women in Mursan expressed despair over the fact that they had many girls to take care of. It is still a reality for the families that girls can involve a financial burden

compared to boys, with the dowry and expenses around marriage. These financial issues get strengthened by the tradition of girls moving away when they marry, and get in-laws to take care of. With the sons functioning as their parents' retirement insurance, it can be very hard for a family to have no sons and many daughters. Whether and how this will be affected by the possible empowerment described is an important area to look into.

8.0 Possibilities for future studies

This study has explored some of the experiences and perspectives of the change toward institutional deliveries. Based on the many concurrencies with findings from studies in other similar settings, the results from this project may be applicable to other settings in rural India. NRHM and JSY are programs covering a large area with varying conditions, and it is obvious that in many places a large distance between theory and practice will be the reality for a long time. This suggests the importance of extended qualitative research as implementation proceeds, to identify factors that facilitate or hamper the development. It also suggests the importance of quantitative research to assess different aspects of the progress.

The “second step”: Quality

Numbers show a clear increase in institutional deliveries, which is described to be the first step in the incentive program. For the near future it will be important to follow the next step, the focus on quality, with assessments and research. Findings from this project and other studies show that it is difficult to measure satisfaction of the users in this field, and it is difficult to assess how quality is perceived by someone who has very few choices. Nevertheless it is important to try to understand how it is understood and experienced by the users, and to investigate factors for improvement and reformation of the services. If, or when, at some point the incentives are removed from the program, the question of sustainability will depend partly upon knowledge of how the program works. Understanding how and why some parts get utilized while others not can then be a key for further planning; it is not enough just to know that the numbers have increased.

Focus on midwives and other health personnel

Several of the subjects addressed in this study are topics of great concern in the professional groups. At the same time, the professionals are the ones who, to a certain extent, manage the development in these topics. Midwives, doctors and nurses work with the implementations on the root level, and they have the responsibility to follow rules and procedures. To study how the changes are perceived by them, and why, can be important in understanding what happens. They are the ones in charge of the daily activity in the centers out in the districts, and this is where the changes are happening.

The over-use of Oxytocin in the institutions will be an important topic for studies with health personnel. Different problems need different approaches, and a malpractice based on lack of

knowledge needs a different solution than if it is due to a conscious effort to make space in an over-crowded facility. In either case, the first step must be to look for the reasons, through research and systematic investigation in the field. It is essential to do this now, before inadequate and inappropriate patterns get too settled through the change.

The midwives' desire to maintain some of the culture from the TBAs is also noticeable. This indicates that there are more aspects to the professional identity and development than just learning skills and adapting new guidelines. The Indian midwife association seemed to be a union mainly for the urban practitioners. They had close relation to the universities and the educational institutions, but there seemed to be a long distance between the union and the midwives working in the rural areas. Among the health personnel whom this was discussed with informally in Mursan, there was no knowledge of the midwife union. With a huge population and geographical distances it is hard to reach and organize the workers in the different areas. To close this gap the researcher suggests investigating possibilities for finding a role for the union in the rural areas, and for research on possible ways to strengthen the midwife profession.

In the attempt to reach the big target of reducing maternal mortality, midwifery in India today seems to have three main challenges. The first will be to educate and train enough midwives to meet the need in the facilities when more women are coming to use the services. The next two major challenges are to keep the natural birth natural and to reduce the gap between theory and practice. For both subjects extended research and increased awareness is needed. This can play a role in maintaining midwifery as separate profession through the developments that hopefully will come with the earlier-mentioned increased focus on quality. Increased research is also essential to call attention to updating procedures and guidelines in the institutions.

Finally the role of the ASHA should be an object for future research. Her work has become very important for utilization of the programs, and the continuation of this should be investigated for making improvements.

Valuable opportunities

Empowerment of women was identified as a potential consequence after JSY, as a possible result of several dynamics. This work suggests investigation of progress and possibilities on the different levels where these changes might come into being. Women are acknowledged in a new way by putting safe deliveries for all on the common agenda, and it was also a hope

from Delhi that what happens in the institutions can contribute to empowerment of the mothers. This will be important subjects to follow with extended research. Another possible aspect of the empowerment of women is the increased focus on midwives, who mainly and traditionally are women, and whether the change can strengthen the respect for and identity of female professions. The ASHA's role in the program and position in society will be relevant to explore also for this purpose.

The researcher also suggests investigating possibilities for reducing corruption in the facilities, to research on the mechanisms for this and inquire whether this can point out how to make improvements. Policy makers and health workers would be particularly relevant groups to look into. For Norway and foreign agents it should be debated whether it is ethically justifiable to support a system where the aid goes partly to maintenance of corruption. It is maybe naive to believe that it is possible to combat what is described as India's biggest problem. Still, if it is not addressed as the challenge it actually is, the international community gives support to an intractable problem.

9.0 Summary

This study intended to explore some of the changes after India's government introduced in 2005 incentives for institutional deliveries as a mean to combat maternal mortality. This initiative was launched as a way of ensuring availability of Skilled Birth Attendance and Emergency Obstetric Care for all women, regardless of financial situation. India is a vast country with extensive cultural and economic differences between people. The policy and the resulting program have first concentrated on quantity, for reaching a large number of women at the same time, with the intention to later focus on quality. Today there remain large differences between facilities, work force, treatment and care. Nevertheless, the women in the Hathras District interviewed in this study were mainly satisfied with the changes.

Different aspects of the change from home births to institutional deliveries were investigated through interviews with women and health officials, supplemented by perspectives from an Indian midwife conference. The analysis of the findings leaves the researcher with a picture of general satisfaction among the women, but not without implications and possible consequences of varying character. This study suggests that moving child births to institutions can involve several possible changes: it can influence and change the traditional view on child delivery being a natural phenomenon, influence the family structure and also possibly be a contributor to empowerment of women. The study suggests that the work of the ASHA plays a big part in the utilization of the programs, and although the women did not report their incentive as a factor for decision making, the incentives for the ASHA are likely to have great importance. The findings also revealed complex economic factors and showed the women were charged for services and medicines that were intended to be free. Even though there is no doubt that for many poor women the incentives make institutional birth an economic possibility, the charges in the facilities raise questions around how to deal with the infusion of money into a system already pervaded with unofficial payments.

The introduction of the NRHM and JSY can be the beginning a massive improvement of health care for women in India. It can make changes on many levels for the community, for the family and for the individual woman. Some of these changes have already come, and some will become apparent in the longer term. The programs are designed for a big population, and the differences in the demography will create different challenges in different states and districts. Through the process of working and evolving the systems, deficits and shortages can and must be explained and justified while continuing to develop in the right

direction. At the same time it is important to measure and monitor what happens. This first phase gives unique opportunities for introducing new practices and new habits, and it is important to utilize these possibilities and not leave it to accidental circumstances. One should also focus on what should remain from previous practices, and not throw all traditions away to make room for the new culture. The gap between theory and practice will still be a reality over the coming years. To investigate what stirs in this gap will be essential for further development.

India is in an interesting chapter of its history. When viewing the situation in the Hathras District from a Norwegian perspective, it is easy to see India as a low-income country, and forget that India's wealth, health, technology and development in many ways are just as good as, or better than, in high-income countries. At the same time the skewed distribution of wealth and the difference between people makes the majority of the population live in simple or poor conditions. Still, as an emerging political and economic power in the larger international community, India has an obligation to continue to work toward reaching global health targets and reducing the MMR. Even though the MMR is improving, with the current pace the numbers will not be reduced sufficiently to meet the MDG5. It is a common responsibility to work together to improve this situation.

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Epilogue

Moment

I hold my breath in a faraway life
painted in colors, in the sun from behind the veil of haze
The heat sticking to my skin, piercing my mind
Keeping us here together in boundless possibilities
Need is another question of who we are
Where to go
What to choose
Who to be

Poem: Marianne Gjellestad

Appendix 1: Question guide for interviews with mothers

1. Introduction

- How was it to give birth? (How was this birth, if the woman is para 1+)
- How did they help you at the hospital?
- (Who decided to go there?)
- How did you reach the hospital?
- Who accompanied you? (ASHA?)
- Why did you deliver at the hospital?

2. Questions about staying at the hospital

- What did you like at the hospital?
- What did you not like/ what could have been better for you?
- Whom did you meet?
- Did you meet a Yashoda?
- What did the incentives mean to you?
- Would you go to the hospital without the incentives? Why/ Why not?

3. Questions about giving birth

- What is the “normal”/ most common way of giving birth in your area?
- Do you know anyone who has delivered at home? If so, who was present to assist?
- Do you know anyone who has been assisted by a TBA?
- Do you know a TBA?
- What are the differences between delivering at the hospital and delivering at home?
- Who would you preferably be assisted by?
- What is the family’s role when a woman is giving birth?
- What is the husband’s role when a woman is giving birth?
- Do you talk about giving birth in the family/ in the groups of women?

4. Questions about the change

- Have you heard that there has been a recent change regarding delivery in your area? If so, how has this change affected you?
- (Do you know where the money comes from?)
- Where will you go to deliver if you are having another baby?

Appendix 2: Question guide for interviews with health officials

1. Can you tell briefly about the JSY? (How does it work and what is the target?)
2. What is/ has been your role in this?
3. Is the target that all women should deliver in an institution? Do you think that all women need to deliver at the hospital? Why? (Probe on normal deliveries)
4. How do you think the women experience getting incentives?
5. Do they pay anything at the hospital?
(Do you know if they spend money on something special at the hospital?)
6. What do you think they spend the money on?
7. What is needed to succeed in this program?
8. What would be the sign or indication that the program is succeeding?
9. Do you believe this program can have consequences beyond the medical benefits? How?
10. Has the JSY-program come to stay or is it a program for a period?
- (11. For NRHM: Have you heard about NIPI? Any collaboration?)
12. About TBAs:
 - Do you know how it works with the TBAs out in the communities?
 - Any collaboration with institutions or NRHM?
 - Are they resources in any way?
 - Probe
13. About ASHA
 - How does it work in the communities?
 - What are their tasks here and how do they collaborate with the hospital?
 - Is the woman/family paying the ASHA?
 - Who did the work of the ASHA earlier?
 - Has the ASHA program come to stay or is it a program for a period?
14. About the Yashoda

Do you have Yashodas here? Probe.
15. What are the biggest challenges of the NRHM and the JSY? What will be the challenges in the future?

Appendix 3: Informed consent form

Inquiry about participation in the research project

"From TBAs to incentive-based institutional deliveries. A qualitative study on women's experiences in Uttar Pradesh, India"

Background and purpose

You are asked to participate in a study about women's experiences regarding child delivery. During the last years there has been a change in your area, where you are now offered money from the government for delivering at the hospital. Many women go to the hospital because of this, instead of giving birth at home. Being a woman who recently has given birth, I would like to interview you, to hear some of your experiences.

I am a Norwegian nurse midwife studying at the University of Oslo. Norway has a collaboration with India, where the countries work together to reduce the maternal mortality.

I plan to stay in Uttar Pradesh for 4 months. During this period I do research on the Indian women giving birth. The information will be used for my master study and will be published in Norway.

What is an interview?

To be interviewed means that we meet and talk. We can meet where is convenient for you, we agree on place and time in advance. Usually an interview lasts for 30-60 minutes. I will ask you questions, and we talk informally. I write down notes from what we talk about, and if you permit it I will also tape record the conversation.

Since I do not speak Hindi my assistant/ an interpreter will be present to translate to English.

What happens with the information about you?

Everything you say will be kept anonymous. This implies that nothing you say will be attached to your person or your name, and in my work you will be represented by a code, ex "mother 1". It will not be possible to recognize your identity. When the information is collected, I will return to Norway for completing my master study.

Voluntary participation

It is voluntary to participate in this study. You can withdraw at any time, even without giving any reason for it. This means that you can stop the interview when it is going on, and you can ask me afterwards not to use the information you have given.

Contact person

If any questions about the study please contact:

Marianne Gjellestad
c/o R.Refsdal
MPHC, Mursan 204213

District Hathras,
UP, India
Phone: 9760 274660
Email: marianne.gjellstad@studmed.uio.no

Consent for participating in the study

I have received information about this study and I participate voluntary:

(Signed by project participant, date)

Proxy/ vicarious consent, when entitled:

(Signed by, dato)

I confirm to have given information about the study:

(Signed, role in the study, date)

Appendix 4: Approval Ethical Committee in Norway (REK)



UNIVERSITETET I OSLO
DET MEDISINSKE FAKULTET

Professor Babill Stray-Pedersen
Kvinnekliviken
Rikshospitalet
Sognsvannsveien 20
0027 Oslo

Regional komité for medisinsk og helsefaglig
forskningsetikk Sør-Øst D (REK Sør-Øst D)
Postboks 1130 Blindern
NO-0318 Oslo

Telefon: 22 85 05 93

Telefaks: 22 85 05 90

Dato: 03.07.09

Deres ref.:

Vår ref.: 2009/163-1

E-post: i.m.middelthon@medisin.uio.no

Nettadresse:

<http://helseforskning.etikk.uio.no/xnet/public>

From TBAs to incentive-based institutional deliveries. A qualitative study on women's experiences i Uttar Pradesh, India

The Committee considered the application during its meeting on June 16th 2009. The project has been assessed in accordance with the Norwegian Research Ethics Act of 30 June 2006; see Ministry of Education and Research Regulation of 8 June 2007 and guidelines of 27 June 2007 for the regional committees for medical and health research ethics.

Theme of the project:

This study will explore women's experiences on the recent change in obstetric care in rural India.

The National Rural Health Mission (NRHM), a program launched by the Indian government in 2005, includes incentives for women delivering in governmental institutions instead of giving birth at home. This is a qualitative study based on in-depth interviews with women who have recently given birth.

The Committee presumes that the project is approved by the local equivalent to the Norwegian Regional Committees for Medical Research Ethics in India.

Decision:

The project is approved subject to the condition that the above comment is incorporated before the project is commenced.

The decision was unanimous

The decision of the committee may be appealed (see Section 28 of the Public Administration Act) to the National Committee for Research Ethics in Norway. The appeal should be sent to the Regional Committee for Research Ethics in Norway, South-East A (see Section 32 of the Public Administration Act). The deadline for appeals is three weeks

from the date on which you receive this letter (see Section 29 of the Public Administration Act).

Yours Sincerely

Stein A. Evensen (sign.)
Professor dr.med.
Leader

Ingrid Middelthon
Secretary

Copy:

- Marianne Gjellestad, IASAM, marianne.gjellestad@studmed.uio.no

Appendix 5: Approval Ethical Committee in India



FACULTY OF MEDICINE
JAWAHARLAL NEHRU MEDICAL COLLEGE
ALIGARH MUSLIM UNIVERSITY, ALIGARH-202002, INDIA

DEAN

Dated14.10.2009

TO WHOM IT MAY CONCERN

I, Prof. Syed Abrar Hasan, Dean, Faculty of Medicine, Aligarh Muslim University, Aligarh on behalf of Ethics Committee, Faculty of Medicine hereby permit Ms. Marianne Gjellestad to conduct study (questionnaire) on women undergoing hospital birth for her project "From TBAs to incentive-based institutional deliveries. A qualitative study on women's experiences in two states in India."

A handwritten signature in dark ink, appearing to read 'S. Abrar Hasan', is written over a series of parallel diagonal lines.

(Prof. S. Abrar Hasan)
DEAN

Appendix 6: Permission from Chief Medical Officer, Hathras

Marianne Gjellestad
c/o R. Refsdal, Director
MPHC, Mursan 204213
District Hathras
U.P., India
Mail: marianne.gjellestad@studmed.uio.no

Mursan, 01.09.09

To Chief Medical Officer, Hathras / *chief medical superintendent, Hathras*

I will with this ask for permission to implement field work for my study in your region. The work will gather material for my Master thesis "From TBAs to incentive-based institutional deliveries. A qualitative study in two states in India."

I am a master student from the University of Oslo, Norway, and this thesis will be a part of my M.Phil degree. Results will be published at the University of Oslo.

My aim is to interview 20-25 women who have recently given birth at the governmental hospital about their experiences regarding child delivery in an institution. Interviews will be conducted by the undersigned, assisted by a local interpreter. If possible, the women will be recruited from both the Hospital, Hathras and the PHC Mursan, and then interviewed in their home or somewhere they find convenient, some days after the delivery.

I will kindly ask for approval for this. If any questions or wish for additional information, please contact me.

Yours sincerely,

Marianne Gjellestad

Marianne Gjellestad

Permission granted
M.C.P.
2/9/09
मुख्य चिकित्सा अधिकारी
जिला महिला चिकित्सालय
महामायनगर